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ORIGINAL ARTICLES.

CLINICAL REMARKS ON A CASE OF TYPHOID FEVER COMPLICATED WITH BRONCHITIS AND LARYNGITIS.

DELIVERED AT THE JOHNS HOPKINS HOSPITAL, APRIL 11, 1894.

By William Osler, M. D.,
Professor of Medicine Johns Hopkins University.

THERE is a patient, whom many of you have seen during the past week at the ward visits, who illustrates two of the important respiratory complications of typhoid fever, and I propose making the case the text of a few remarks.

J. H. W., aged 26, fireman on a steamer, admitted April 3rd. He had been ill three days en route from the West Indies. The illness began March 27th, with pain in abdomen, vomiting, and subsequent looseness of the bowels. On the following day he had a slight chill; since then he has felt "hot and cold." From the outset he has had cough with slight shortness of breath. He has always been a healthy man and has a good family history. On admission the temperature was 102°, and rose to 104.5° in the evening. The pulse was 104°, respiration 36. The tongue was red, smooth and glazed. There were several suspicious looking spots on the skin of the abdomen. The spleen was readily palpable. Respirations on the morning of admission were 40. On percussion the lungs were clear in front, but at the left base the resonance was slightly defective, and there were fine crepitant râles in the infra-scapular and outer axillary regions on this side. There was no leucocytosis. He was ordered baths every two hours and the usual milk diet.

On the 5th and 6th the temperature kept between 103° and 104°, and was not much influenced by the baths. The cough, which on admission was quite slight, has during the past two days become more marked, and there are signs now of general bronchitis at the bases of the lungs; coarse and medium-sized râles are heard everywhere; no dullness; no blowing breathing.

On the evening of the 7th it was noticed that the patient was somewhat hoarse, and he complained of pain in the throat. The expectoration has been muco-purulent, somewhat tenacious, not rusty-colored, but presents a few streaks of blood. Microscopically there are no pneumococci.

On the 8th, the temperature in the evening reached 105°; his cough seemed so much worse in the afternoon that the baths were omitted and sponging substituted. His pulse keeps of good volume.

On the 9th the resonance was slightly defective at both bases; the râles were numerous, medium in size; some piping. They were heard as high as the middle of the scapula; no tubular breathing.

10th. Patient was flushed, but the color kept good; respirations have been from 32 to 40 for the past two days. The pulse was 104, of good volume and dicrotic. The resonance was good in the

front of the chest, but defective at both bases, and the respiration was here feebler and accompanied by numerous medium coarse râles. The sputum was thick and somewhat tenacious. The hoarseness had increased, and the voice was very husky. There was no pain over the larynx and he says the throat was not sore. He swallowed well. The rash was abundant. The cold sponging had very little influence on the temperature. For nearly forty-eight hours the range has been scarcely a degree between 103.5° and 104.5°. This morning, as many of you saw, he is comfortable and says he feels well. The physical signs persist—defective resonance with feeble breathing at the bases and occasional piping râles in other parts of the lungs.

The special features of this case, then, are the bronchitis and the laryngitis.

With the exception of measles, perhaps no febrile disorder is so often associated in its onset with bronchitis. The patient may indeed come under observation with shortness of breath, moderate fever and an acute inflammation of the bronchial tubes, as indicated by fine, whistling rhonchi, and for some days the case may be regarded as one of simple bronchitis. A young woman was admitted to the Philadelphia Hospital under my care with slight cyanosis, dyspnœa, and gave a history of an acute bronchial attack, which had lasted for four or five days. With the use of jacket poultices externally the bronchitis subsided, but the fever persisted, and within a week the rose spots and enlarged spleen showed that we had had in reality a case of typhoid fever. This initial bronchitis is general and piping râles are heard in front and behind. The cough may be very distressing, and though as a rule the condition is not serious, it is sometimes followed by the more serious pulmonary complication of pneumonia. The patient whose case we have been considering had apparently from the onset a bronchitis which at present is limited chiefly to the lower lobes and associated with the slight congestion so common in this disease. The resonance is somewhat defective at both bases; breath sounds are weak, not tubular, and on quiet breathing medium-sized, bubbling râles are heard. On deeper inspiration piping râles occur. Such signs indicate congestion and infiltration of the lung tissue, not actual pneumonia, in which the dullness is more marked and the blowing breathing quite pronounced, and the râles smaller.

Mild laryngitis is not very infrequent, and is perhaps more common in the cases treated by baths. It is indicated by slight huskiness of the voice, not accompanied with pain. It does not necessarily indicate that ulceration is present, and in fact the ulceration may be extensive in the epiglottis and contiguous parts without causing any symptoms whatever. Although a case may start as this has done with simple, slight laryngitis, one cannot help feeling uneasy when we remember the very serious character of many of the laryngeal complications. You will find in our recently issued report on typhoid fever that in one of the fatal cases death was caused by œdema of the glottis. The symptoms began with hoarseness, which after persisting for three or four days became associated with great difficulty in breathing. The huskiness may be also only a preliminary feature of the most extensive diphtheritic pharyngo-laryngitis, or the beginning of a process which may finally lead to extensive necrosis and sloughing. The entire question of the laryngeal complications of typhoid fever have been most elaborately considered by Lüning in Vol. xxxi of the *Archiv. für klin. Chirurgie.*

The preliminary slight bronchitis of the disease rarely requires any special treatment. When severe and associated with dyspnœa repeatedly changed jacket poultices often give great relief. Ipecacuanha with preparations of ammonia, rarely antimony, may be employed, and at night to procure sleep a full dose of Dover's powder. In the bronchitis associated, as in the case under consideration, with more or less hypostasis, changing the position of the patient from side to side is important, and special care should be taken to watch the action of the heart, and heart stimulants

with preparations of ammonia are perhaps our best aids.

A very important question always arises in these cases with pulmonary complications: Shall the baths be continued? As a rule they may, and we regard neither the bronchitis nor the pneumonia as in themselves contra-indications. In this case we omitted the baths rather on account of the increasing hoarseness. For the laryngitis he has had inhalations, and the application of an ice-poultice to the neck, which, as he expressed himself this morning, had given great comfort.

NOTES ON AND PERSONAL EXPERIENCE WITH PUERPERAL MANIA.

READ BEFORE THE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE, MARCH 13, 1894.

By G. Lane Taneyhill, A. M., M. D.,
Vice-President Obstetrical and Gynæcological Society of Baltimore; Ex-President Baltimore Medical Association; Secretary Medical and Chirurgical Faculty of Maryland; Member American Medical Association; Formerly Assistant Physician Maryland Hospital for the Insane.

THAT careful observer and conservative writer of fifty years ago, Ramsbotham, classifies the subject under consideration into *two distinct forms:* (1) the one attended with great excitement and furious delirium; (2) the other characterized by the features of low melancholy. A more modern author, Lusk, mentions the subject under three subdivisions. The insanity (1) of pregnancy, (2) of childbed and (3) of lactation.

When we consider how active are the causes of psychical disturbance in women during their child-bearing period, we need not be astonished at Tuke's assertion, that, of the insane admitted to asylums, in one-eighth the affection is of puerperal origin.

Frequency of the several forms.—Of the seven cases that I have treated, five were of the excitable, furious form, and I am inclined to believe that this form constitutes a majority of the cases, for I observe that Burrows, in his "Commentaries on Insanity," 1828, out of a total of fifty-seven, noted thirty-three as maniacal, sixteen as melancholic and eight as alternating. This is confirmed by Playfair, who in his third American edition states that the relative proportions of each form, per hundred, are:—Insanity of Pregnancy, 18 per cent.; Puerperal Insanity, 47 per cent.; Insanity of Lactation, 34 per cent.

On account of the limit of this paper and because a greater number of my cases have been of a furious or maniacal form, I shall not consume your time by any lengthy reference to the melancholic type. Nor will I treat of or cite any of the cases originating during pregnancy. Insanity from "lactation," with all its untenable theories and speculations, will be reserved, as far as the writer is concerned, for a future occasion, but tonight we hope for a few minutes to interest the society in that one form of puerperal insanity denominated by Ramsbotham as "Puerperal Mania," attended with furious delirium, by Lusk as the "Insanity of Childbed," and by Tuke as "Puerperal Insanity Proper," that is, "insanity coming on within a limited period after delivery."

Predisposition.—Women of an excitable temperament and those who are apparently endowed with acute feelings, have shown themselves to become more frequently the victims of this most distressing affection. The mortification experienced by unmarried women would seem to indicate that they are more disposed to puerperal mania than the mar-

ried. Esquirol reported 29 as unmarried out of 92 cases of puerperal mania. Kerchoff, in his "Hand-book on Insanity," expresses the opinion that these illegitimately pregnant women are attacked more frequently, because of the fact that they are exposed to numerous other harmful factors.

Causes.—Were an alienist asked the predominating cause of puerperal mania or insanity, he would most probably remind his questioner of "that undue excitability of the nervous system, always in a greater or less degree present during pregnancy, labor, and the chief portion of the process of lactation." The much commented on cause of mental aberration, "hereditary taint," can, from experience among this class of cases, be cited as a frequent cause. Burrows, in an able article in the *Medical Gazette*, informs us that of eighty lying-in women who became delirious, over half had an hereditary disposition to insanity.

Terror was an exciting cause in one of my cases, the unfortunate woman having been taken out of a house near a burning building; and one I recall in which I assisted in the treatment in May, 1865, who was said to have been thrown into a state of puerperal mania by alarm, the consequence of suddenly seeing a large number of soldiers passing near her house in St. Mary's county. Writers also refer to "sudden and unusual agitation" consequent upon the sad news of the death of a dear relative as one of the occasional causes of this affliction.

There are cases on record in which diseases antedating pregnancy, profuse loss of blood and eclampsia have been considered as proximate, but not necessarily fundamental causes of puerperal mania.

Sir James Simpson, having found albumen in the urine of four patients, originated the idea of this form of mania depending on septicæmia; and Dr. Donkin, in Vol. VII of the *Edinburgh Medical Journal*, strongly sustains this view and calls it uræmic or renal puerperal mania, thus tracing it to the same pathological condition which is supposed at times to cause eclampsia. Playfair partially combats this theory by the criticism that "the albuminuria is transient, while its supposed effects last for weeks or months, and asks the pertinent question, Why should uræmic poisoning in one case give rise to insanity and in another to convulsions?"

Symptoms.—Although she may do odd things, be unusually irritable, impatient, vacillating, be suspicious and unnaturally anxious, yet the relatives will probably not comprehend the sad experience that is about to ensue until the patient will suddenly (even after a quiet, refreshing sleep I have seen it) break out in a torrent of invective more or less incoherent, against her husband or some dear relative. These will often be followed by listlessness, obstinacy and an absolute ignoring of the fact that she has given birth to a child; or, she will insist that the child has died or is the child of another. I have known some alienists to flatter themselves with the belief that with their practised eye they were enabled to detect the on-coming puerperal mania from observing the countenance or the general demeanor of the patient, but I have found them as often mistaken as correct.

In my efforts to control a puerperal maniac during my early experience, I was impressed by the revengeful and striking tendency of one of the most beautiful and respected ladies who had graced the society of Baltimore, by finding myself felled to the floor by her one night in my effort to place a camisole (a modified straight-jacket) around her person. This same lady indulged in the most vulgar expressions I had ever been compelled to hear. The older writers on this subject call attention to the fact that immorality and obscenity of language are peculiarities attending the unfortunate victim of puerperal mania; and from perverseness, obstinacy or inattention more than from a want of consciousness they will void their feces or urine more probably in bed or in the chair than in the commode. Occasionally the lochia are suppressed, the bowels constipated and there is such persistent insomnia that the tolerance of anodynes is almost incredible. Some authors think they discover a peculiar

odor from the exhalations of the skin in cases of puerperal mania. In the melancholic form the fear and dejection of spirits partake of a religious nature, the patient seldom speaking of anything except her regret that her soul will be lost.

Differential diagnosis and simulating diseases.—Gooch, in referring to this affection in his work on "Disorders of the Mind in Lying-in Women," calls attention to one case which strikingly resembled delirium tremens, to which condition men of hospital experience must admit certain classes of women are subject. But the ordinary proofs of indulgence in liquors or the contrary readily reveal the true nature of the case except where the stimulating physician or meddlesome midwife has overdosed the excitable puerperal unfortunate with too much whiskey. In 1867 I was called from the old Maryland Hospital for the Insane, in consultation, over an alleged case of puerperal mania which the relatives had declined to commit to the hospital, and astounded the relatives and disconcerted the physician by the opinion that we had a case of delirium tremens; my "presumptuous expert opinion" was only coincided in after a change to a trustworthy nurse and a lapse of three days, with morning purging by Epsom salt and a nightly potion of thirty grains of bromide of potassium.

In my limited experience I have had more difficulty in diagnosing the affection from phrenitis than any other disease; phrenitis, encephalitis, or acute delirium, however, although like puerperal mania, being characterized by violent and furious excitement, is generally more apt to be developed sooner, accompanied with or preceded by tinnitus, vertigo, and excruciating pain in the head, with fever, hard pulse, congested eyes, and intolerance of light or sound, whereas in puerperal mania we generally have a quick but not a hard pulse, the eyes not congested, and the face, instead of the flushed cheek, is pale, and impresses one as if the patient were suspicious of some betrayal or calamity about to ensue, and there is marked incoherence especially in the conversation of the patient. I have seldom observed any inflammatory fever in the puerperal maniac, and as to light and sound, I have seen them look straight at the mid-day sun; and, also, not be impressed in the least by any surrounding noise. I shall never forget the lesson I was taught in 1866, by the good old superintendent of the insane hospital, Dr. John Fonerdon, under whom I was serving, when I failed to clearly discriminate between puerperal mania and phrenitis, in my attempt to bleed and purge a case which had been brought into the hospital a raving maniac the night previous—by his prompt intervention the probably fatal consequences were averted; however, neither the city medical attendant nor the terror-stricken relatives who brought her to the hospital had informed me of the fact that ten days previous she had been confined, or I would have called to mind Ramsbotham's remark, "Rare as puerperal mania is, phrenitis under child-bed is a still less frequent disease."

Prognosis.—Many writers give a favorable prognosis—in fact, Dr. William Hunter, in his lectures, treats the subject so lightly as to denominate it as a "species of madness that generally cures itself." My fatal cases were those in which there was a continuously rapid pulse, the attacks supervening very soon after delivery, and characterized by the wildest maniacal expressions and actions; those which recovered improved first in physical health, and soon complete mental equilibrium followed. The melancholic cases, on the contrary, seldom recovered mentally, but gradually subsided into confirmed melancholy. The few statistics to which I have had access are as follows: Esquirol had 55 recoveries, in 4 years, in 92 patients, and Burrows reported 57 cases as follows: 35 recoveries, 11 remaining uncured, 10 died and 1 committed suicide.

A greater part of these statistics, it must be borne in mind, is compiled from the cases of experts in hospitals, many of their cases having been brought under their care after the golden opportunity of treatment, namely, the first week or so, had passed; then, too, there are what may be termed brief cases,

which are never placed in institutions. Lusk is of the opinion that more than 60 per cent. of the cases end in recovery.

Post-mortem revelations.—I have seen only one post-mortem of a subject of this distressing malady, and could only observe the marked absence of blood in the brain. If there be any post-mortem signs as a basis of opinion, I am not aware of them.

Treatment.—In the furious and maniacal cases restraint and seclusion are absolutely necessary, and the proper place is in an institution, preferably on the "cottage plan," where she may not be disturbed by the frequent noise of other maniacs as she becomes benefited by the medical treatment exhibited. If she is not allowed to be removed to an institution on account of the prejudice or pecuniary circumstances of the family, a room in a quiet part of the house should be chosen, the window sashes fastened by screws, leaving sufficient space for ventilation, and all implements and furniture removed with which she might injure herself or attendants, one of whom must be constantly present; for these patients frequently display great propensity to suicide. My experience has sustained the belief that kindly disposed trained nurses of a matronly bearing have more influence with these patients than any relatives; in fact restoration is more rapid where interviews with husband and relatives are interdicted, unless the patient herself in a lucid interval requests their presence.

In this, as in many other mental disorders, time is an important factor in the treatment. Here, too, can be quoted the stereotyped but excellent advice to "combat the morbid symptoms as they arise;" do nothing that may tend to further exhaust the patient, but allay the nervous excitement which is almost always present. I am not an advocate of indiscriminate purging, but it is almost incredible how readily even physicians may be deceived regarding the actual condition of the bowels and their contents; and as this disease is admitted to more frequently arise from disordered functions than from any organic disease, the free evacuation of the bowels has in some cases been promptly followed by an amelioration of the symptoms if not by a complete restoration of normal mental function. Some years since a medical friend took umbrage at my incredulity in a case of this kind regarding his assertion that the bowels had been freely evacuated. While the patient was struggling in a paroxysm of excitement I availed myself of the opportunity to make a vaginal examination, and thus satisfy myself of the condition of the rectum; I found it loaded, but said nothing; the doctor reluctantly consented to a three-quart enema of hot soapsuds; the patient retained it, and continued to retain it, the doctor remarking in a jocular way that my water had "gone up;" I accepted the laugh of himself and nurse, but waited ten or twelve minutes for the next paroxysm, when a prodigious quantity of unhealthy and offensive matter was expelled from the rectum, both the odor and noise of which he asserted was the loudest he had known from any human being; on the next day there was but one paroxysm of maniacal demonstration and four days subsequently her delusions had vanished; it is proper to state, however, that each morning she received a warm sponge bath, and each night a half grain of morphia hypodermically. This brings me to the consideration of internal medication in these responsible and annoying cases.

Knowing that "excitation is not inflammation" and as Burrows says, "muscular exertion is not vital power," I will not waste your time by arguing against blood-letting as advocated by some of the older authors in this disease; nor have I seen cases in which blistering the forehead and cupping the back of the neck were of much benefit. After being assured that the bowels are actually freed from all offending matter, there is no medicine that I know of so applicable, satisfactory and valuable as morphia. By watching the circulation and respiration we can administer half-grain injections of morphia hypodermically without fear of any marked deleterious effect on the brain; what we want is sleep, and an abundance of it.

If the action of morphia is resisted, as we well know it occasionally is in many forms of mania, I resort to rectal injections of hydrate of chloral, 40 grains, in a gill of warm milk; and, if paroxysms of excitability and the jactitation of the body, which so often abort our medication per rectum, supervene, I have found bromide of potash, 20 grains, with 30 grains of chloral, by the mouth, compose the patient, but there is no remedy so available and satisfactory as morphia, if it be absorbed. I never feel justified in using powerful sedatives, such as antimony or hydrocyanic acid, referred to by Jeffery in the *London Medical Gazette*, nor would I be inclined to administer camphor and henbane, mentioned in "Denman on Mania Lactea." The astonishing waste of tissue in the disease demands a free and full diet; I have absolutely forced food in the patient's mouth, and it is surprising the amount they will eat after they are apparently convinced that you intend to compel them to receive the food.

In 1868, as a beautiful young married woman was discharged from the old Maryland Hospital for the Insane, sound in mind and body, I remarked to Prof. Fonerden, the superintendent, that it was sad to think she had any ovaries, implying of course that she should not be subjected to the liability of conception. I find that Goodell, at the International Medical Congress of 1881, remarked that every insane woman should be deprived of her ovaries. I am not prepared to express so radical an opinion as that, but I am rejoiced to know that a member of our own society, according to the *American Journal of Obstetrics*, 1892, Dr. Geo. H. Rohé, had the courage to "bring to the test of experience this hypothesis," at least in a moderate number of cases, four of which were puerperal mania. On page 312 of the "Year-book of Treatment for 1894," we read the following report of these cases: "Two were improved, but not cured, and two left the asylum quite well—one two months and the other nine months after the operation." I think a conservative man might venture the opinion that at least in cases of recurrent puerperal mania where the sexual disorder is clearly responsible for the insanity, the ovaries ought to go.

In convalescence it is hardly necessary to state that we should recommend a change of location, and thus with new environment and in the constant presence of an intelligent, entertaining nurse as a companion, and with very few if any visits for several months from relatives, we may reasonably expect complete restoration.

1103 Madison Avenue.

Physicians Cannot Testify.—The policy of the law is to make the relation of physician and patient confidential and sacred. Only the patient himself, or, in case of his death, his legal representative, may waive the seal of secrecy and confidence. Thus holds the Supreme Court of Indiana, in the case of Gurley *vs.* Park, decided November 23, 1893. The application given to this doctrine here is to the effect that in a case where there is no legal representative, as administrator or executor of a deceased person to make waiver, the physician who attended her cannot testify in an action to set aside her will as to her mental condition at the time she made the will, he being present in his professional capacity. The law, this court says, forbids the physician from disclosing what he learns in the sick room, no matter by what method he acquries his knowledge.—*Journal American Medical Association.*

President Judge Hanna, in delivering the opinion of the Orphans' Court of Philadelphia, in the case of Waesch's Estate, says: The liability of the husband for medical attendance upon his wife, even although she has a separate estate, is too well settled to admit of argument. He is primarily liable, and her estate is liable only in case he be insolvent. If any balance then remains for distribution, the expenses he should have paid will be deducted from his distributive share.

SOCIETY REPORTS.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MARCH 16, 1894.

THE 293rd regular meeting was called to order by the President, Dr. J. Edwin Michael.

Dr. Randolph Winslow reported two surgical cases and exhibited the patients.

1st: A case of GASTROSTOMY FOR CICATRICIAL CONTRACTION OF THE PHARYNX.

The patient, a colored child, age three years, was admitted to University Hospital September 8, 1893. Several days previously he drank some concentrated lye, which caused great inflammation and ulceration of the pharynx, followed by contraction. Deglutition was difficult and he could only swallow very small quantities at a time. Several attempts were made to pass sounds through the stricture while patient was under chloroform, but with poor success. He became emaciated, temperature reduced to 95°, and on one occasion to 90°, and his pulse became rapid, irregular and thread-like. As he was starving from inability to swallow sufficient nourishment, and as I believed could scarcely live more than a day or two, I determined to perform gastrostomy.

The operation was performed November 27, 1893, by Frank's method, in two stages.

He was then fed through the fistula and, the canal being oblique, there is no leakage except when the stomach is very full. He takes milk, raw eggs and whiskey and cod liver oil in this way by means of a tube and funnel and has also become able to swallow liquids and soft foods again. The skin around the fistula is not excoriated and he suffers no inconvenience. Subsequent to the operation his temperature became normal and his pulse good and regular.

2nd: Case of GUN-SHOT WOUNDS OF THE INTESTINES; LAPAROTOMY AND CURE. Patient, white, male, aged 60, admitted to hospital December 22, 1893. Had been shot eighteen hours before I saw him, the ball entering the right iliac region, about two and a half to three inches to the inner side of the right anterior spinous process, and about same distance from Poupart's ligament. The wound was small, with discolored edges, temperature 101°, pulse 104. An incision was made through the track of the bullet, which led into the peritoneal cavity. Considerable free dark blood was found, flushed out, the intestines examined and four wounds leading into the lumen of the bowels were found. Some fecal and foreign bodies were also found in the peritoneal cavity. The wounds were all in the ilium, three close together, while the fourth and largest was eight to twelve inches distant. Lambert sutures were used for closing these wounds and as there was some bleeding from behind the peritoneum the abdominal incision was left open. The bullet could be felt under the skin of the buttock.

December 28, the abdominal wound was closed, healing proceeded nicely and all was well until January 4, 1894, when temperature suddenly rose to 102.-1-5°. An examination showed an induration of tissues in the iliac fossa; an abscess was supposed, an incision made and some purulent fluid escaped, followed by free hæmorrhage.

The missile was also extracted at this time. It was scarred and had passed through the ilium and lodged in the buttock.

On January 10, a pulsating lump developed in the right iliac fossa, and he was again chloroformed and an incision made along and above Poupart's ligament, to expose the deep circumflex iliac artery, which was ligated and no further trouble occurred.

He was practically well from the intestinal wounds in a few days, but on account of the wound made in the last operation he was not entirely healed until March.

Dr. Robert W. Johnson: I should take exception to the rule of performing laparotomy for all perforation wounds of the abdomen. Wounds produced by small bodies, such as the smaller calibre bullets, shot, etc., will often do well without operation, so unless we have evidence of fecal extravasation or sepsis

following such wounds, I do not think it necessary to open the abdomen.

Dr. L. McLane Tiffany: Dr. Johnson raises an important question, viz.: How can you tell from external appearances what damage has been wrought inside the abdominal cavity? I do not think you can. It is impossible. A ball passing through the cavity from side to side I think always cuts the bowel—from before back not so—but I do not think there is any sign from the outside of fecal extravasation, unless we wait some time, and in such a case the delay is more dangerous than an operation would be. I operated on one case three weeks ago, in which the missile had entered laterally and produced nine wounds of the small intestine and four of the mesentery. He is now well. I recall another case in which there were twenty-five wounds of the intestines and two of the bladder, and yet no external signs to indicate internal wounds. It may be there is no extravasation from very small wounds. I have not seen such cases, however, and would prefer to operate even here.

Dr. J. E. Michael: I am inclined to the view of Dr. Johnson in regard to small wounds by small projectiles.

Dr. Michael then reported three cases of wounds by small projectiles upon which he did not operate, and which got well, and said: I suppose the proper thing to do is to operate as Dr. Tiffany has said, especially when the course of the object was from side to side, but I have not yet come to the point of thinking that laparotomy is an entirely safe operation. I suspect that if we were to count up all cases of gunshot wounds of the abdomen operated upon, we should not find such beautiful statistics as are now supposed to exist.

Dr. J. W. Chambers: If there is one rule of surgery that is a good one I think it is that "when we have a perforating wound of the abdomen it is our duty to find out what organs, if any, are injured." I should not consider the size of the projectile, but examine all.

You cannot tell much from outside symptoms. Shock, etc., is not to be depended upon. Some very grave cases have very slight shock and *vice versa*. The danger of opening the belly is slight compared to the risk attending delay. Even a small perforation will be safer with a Lambert suture in it.

Dr. R. Winslow: If I were shot in the abdomen I should want to be opened up and if any intestinal wounds were found have them attended to.

Certain cases do recover without operation, but who can say that in those cases the intestines were hurt.

Dr. Wm. Osler then read a paper on CHOREA AS A CAUSE OF VALVULAR DISEASE OF THE HEART.

H. O. REIK, M. D., Secretary.

CORRESPONDENCE.

HOME FOR EPILEPTICS.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—The King's Daughters of this State, an organization which includes in its membership King's Sons as well, have inaugurated a movement to establish a Home for Epileptics in Maryland on the colony plan.

The project has been smouldering in the breasts of many of the King's Daughters for a long time, but the way did not seem clear to make a move until a property was offered to the organization by a philanthropic person, whose name has appeared in the daily papers. The organization was immediately incorporated, and the gift accepted. The various circles of which the King's Daughters is composed have been hard at work, and more than fourteen hundred dollars has been pledged, a large part of which is available for immediate use. The necessary repairs upon this property will therefore be commenced immediately, and it is confidently expected that the Home will be ready to receive patients by the first of July.

It was my privilege some time ago to visit the property at Port Deposit, which has been devoted to the King's Daughters, and which it is their purpose to utilize for the present.

The donation consists of about three acres of ground, having upon it an old-fashioned house in very good condition, not ill adapted to the purpose of such an institution, at least in its embryonic state, which will with some slight alterations and repairs accommodate fifteen patients. The property is situated upon a bluff overlooking Port Deposit and miles of the broad Susquehanna. Adjoining is a farm of two hundred and sixty-three acres, tillable, well-watered and fertile. An option has been secured upon this property with a view of its possible acquisition.

So much has been accomplished in the past few months I will not dwell upon the anticipation of the promoters of this charity, further than to state that that broadest of philanthropies, the Bethel Epileptic Colony at Bielfield, near Hanover, Germany, established by Pastor Von Bodalschwingh, a Lutheran clergyman, is at the same time an inspiration and an example.

We are perhaps not permitted to pass judgment upon the relativity of human misfortune, yet when we consider the epileptic in the light of the attitude maintained toward him by the public, he is the most pitiable outcast of society.

Maryland may be justly proud of her magnificent array of charitable and beneficent organizations. Almost every sort and condition of need incident to our social system has been met by the great diversity of our institutions, many of which are an honor to the State and might well be examples to the world. But the epileptic has been strangely forgotten. He is received into our insane asylums if he suffers from some mental derangement, but he is not considered a desirable patient in such institutions. As a matter of fact the number of insane epileptics in our asylums is comparatively small. In the State asylum at Spring Grove, for instance, there are twenty-four; in the insane department at Bay View, thirty-five; at Mount Hope a somewhat larger number. Inasmuch as a large proportion of feeble-minded children are epileptic, there are a few at the Home for Feeble-Minded at Owings Mills. But only a comparatively small proportion of epileptics suffer from the more serious forms of mental derangement. It is estimated that less than ten per cent, of all epileptics are insane. For the other ninety per cent. there is absolutely no provision. But this is not all. There is hardly a field of effort or usefulness in our whole complex civilization into which an individual known to be epileptic is welcome. Not only is he shunned by society, but he is robbed in many instances of the means of gaining a livelihood by his sad affliction.

This state of things is the more deplorable in view of the fact that he is perfectly able in the majority of instances and can, as has been demonstrated in certain notable cases, occupy any sphere of life, were it not for the proscription which has been stamped upon him by his infirmity. Since the majority of epileptics are persons of ordinary intelligence it is easy to understand how existing conditions react upon them, and the moral and mental apathy which is developed in time and which is so characteristic of the class is no more to be wondered at than that those who depend upon their own exertions for a livelihood should drift into pauperism and vagrancy, and finally become wards of the State, to be harbored in jails or crowded into some uncared-for corner of a poorhouse, there to moon away their fitful existence and at last to die years after they have been forgotten by the world.

The medical profession of this State has long been alive to the necessity of special provision for the epileptic and a great deal has been written and said to arouse public sentiment in this direction. Now that a definite step has been taken, and especially inasmuch as it has been taken by so worthy an organization, we should use every effort to encourage and further the project.

Yours truly,

Frank Dyer Sanger.
18 W. Franklin St.

A recent count gives Maryland 2120 physicians.

MEDICAL PROGRESS.

THE USE OF CERTAIN ANTISEPTICS IN MIDWIFERY.—The proper use of antiseptics has reduced the mortality after childbirth to a great degree, and the old expression "milk fever," is a thing of the past. The most commonly used antiseptics have been bichloride of mercury and carbolic acid. They are both very efficient, but are so irritating that they often cause poisoning when used too zealously. Dr. Edward E. Morse (*American Journal of Obstetrics*, April, 1894) has been much pleased with the use of creolin and lysol instead of the more irritating antiseptics and thinks from their combined properties of efficiency and harmlessness, they approach nearer the ideal antiseptics for midwifery than any others in common use, and he adds in conclusion that by first immersing the hands in a solution of the bichloride and then using creolin or lysol the maternal parts are quite protected from contact with the corrosive, and the danger arising from such use is avoided.

***

PERTINENT FACTS ON VACCINE VIRUS.—Dr. H. M. Alexander gives the following advice in regard to vaccine virus and vaccination:

Keep in a glass-stopper jar in an unheated room in winter and in a refrigerator in summer.

Do not carry in an inside pocket. Do not use too much water. Do not abrade too large a surface. Do not use any dressing. Do not report until the eighth, or, better, the tenth day. Our plan of operating is as follows:

We scarify by scraping off the scarf-skin from a surface about one-fourth of an inch square over the insertion of the deltoid muscle, scratching the surface thus abraded in two directions. We touch one side of the ivory point with a drop of water, immediately shaking the excess off; rub this side briskly on the abrasion and then form a paste by using the dry side of the point. We finish the operation by gently scratching the virus in with the point we have used. We are then certain of getting some of the vaccine corpuscles within reach of the mouths of the absorbents. Too much water with the serum that exudes from the arm, frequently washes away the corpuscles, while too thick a paste, if not pricked in, will dry as a varnish, beyond the reach of the absorbents which have been closed by the rubbing process.

If you protect with a shield, see that it is properly ventilated. Failures result from using unhealthy or poorly fed cattle, pressure used in removing lymph, the clamor of physicians for colorless points, hot mail-cars, drug stores and physicians' offices, improper methods of operating, old goods, or mucilage and croton oil points, sold at cut-rate prices, while human lives are sacrificed.

***

NERVE SUTURING.—When drugs fail, surgery often comes in and effects a cure. The fact that severed and even exsected nerves will unite when such a thing is not desired and also that ends of nerves at times will not unite even after the most careful suturing, has led Dr. De-Forest Willard to perform some experiments on animals in nerve suturing. He operated on dogs and after suturing the nerve ends he let the animal live until the function of the nerve was restored and then made a post-mortem on the killed animal and examined the sutured part of the wound both macroscopically and microscopically and from his work published in the *International Medical Magazine* he thinks he has demonstrated that:

1. Functional restoration is possible.

2. The closer the apposition the more speedy and complete will be the restoration.

3. Union is accomplished chiefly by the reaching out and development of nerve-fibres from the divided proximal end, these fibres pushing their way across the connecting link of fibrous tissue. The fan-like projection of these fibres is marked in each case.

4. Engrafted nerve-tissue or flaps cut from the nerve may serve as a framework for new tissue, or may produce embryonic nerve-fibres capable of assisting in reunion.

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See Publishers' Department, page 18.

BALTIMORE, APRIL 21, 1894.

ANNOUNCEMENT.

THE transformation which has been wrought in the character and appearance of the JOURNAL since its last issue, as evidenced in the present number, may be regarded as the expressed intention of the management to advance the publication to the front rank of Medical journalism. Emanating as it does from one of the most important medical centres of the Western Continent, and at the same time enjoying the distinction of being the only *weekly* of its class in the South, the JOURNAL has an important function to perform. In full recognition of these facts it enters upon a new regime with well-equipped editorial and business departments, and in possession of other necessary facilities for the attainment of its aims. The entire property of the Journal Publishing Company has been transferred to the ownership of the Health Magazine Company, a corporation embracing among its co-operators representative citizens in the professional and business circles of Baltimore and Washington. All that energy, devotion and careful management can secure toward the advancement of the JOURNAL'S interests will be brought into requisition. It is due the original projectors and former proprietors to state in this connection that the labors bestowed in establishing the publication and in maintaining it throughout the vicissitudes common to such enterprises, make feasible the plans and purposes of the present management. Under these hopeful and inspiriting conditions the MARYLAND MEDICAL JOURNAL enters upon its thirty-first volume, being the seventeenth year of publication.

WE shall esteem it a valued favor on the part of any of our cotemporaries who may kindly mention the Journal in their columns, if they will send us a marked copy calling our attention to the fact.

EDITORIAL.

The Medical and Chirurgical Faculty.

THE preliminary programme of the forthcoming meeting of the Medical and Chirurgical Faculty of Maryland, recently issued by the Committee on Programme, calls attention to the importance of the Annual meeting and invites the coöperation of the profession in the effort to make this meeting one of more than usual interest and importance to the profession of this State.

The abandonment of the old method of work by sections and the adoption of the method of soliciting individual contributions and of selecting special subjects for discussion, will materially change the character of work presented at the coming Annual meeting. The Committee is, therefore, anxious that the meeting near at hand shall show the true value of the new method, and its superiority over the method employed for so many years. At this time of writing, the Committee on Programme has received the promise of more papers than have ever been offered at any previous meeting of the Faculty, and it is believed more matter will be presented than the Faculty can dispose of during its four days' sessions.

The profession of this State is beginning to appreciate the value of the Faculty as a means of professional organization, and the indications are that a large addition will be made to its membership.

We feel that this is an opportune time to refer to the past, present and future value of this organization as a professional influence. In 1899, as already stated, the Faculty will celebrate its Centennial Anniversary. In point of age and influence, it presents a history which should command respect and pride. It was the sixth State medical society organized on the Western Continent, being preceded by the medical societies of New Jersey, Massachusetts, Connecticut, New Hampshire and Delaware. In point of plan of organization and scope of influence it outranks any of its predecessors, and can justly claim to be the pioneer in the larger work of thorough professional organization. The Charter granted to the Faculty by the Legislature of Maryland in 1799, conferred larger powers and privileges than had been granted to any similar medical society. The founders of the Faculty builded wiser than they, perhaps, considered and in organizing the

Faculty constructed a model for future organizations, which time has not improved upon. The Faculty was the first State medical society which engaged a legal authority to regulate the practice of medicine. In this respect it enjoyed a control over the profession of the State, which is now universally regarded as one of the most important privileges a State medical society can exercise. In the exercise of this function it was the pioneer of the present movement in favor of examination and registration of medical practitioners.

The Faculty was the first society in this country to divide its work into sections and to exact reports from the societies on the progress of medicine during the year. This plan of work was copied by the American Medical Association from the Faculty.

It very early adopted the plan of having public addresses on medical topics. It was among the very first to offer prizes for essays and lectures. It was the first State medical society to organize a library and museum, and, the only State society now, we believe, that owns a library and museum. It was the first medical society to conduct a medical journal. From the very beginning it has issued an annual volume of transactions which presents a record of work not improved by any organization in this country.

The influence of the Faculty upon the medical profession of this State and of our country was pre-eminent in its history. It was a model which has found wide influence and favor in the work of general organization. Its influence in this State began to narrow in 1840 to its own membership. It lost its characteristics as a State society and became a local body of high tone and authority. This was due to the loss of its influence as a licensing power.

Within the past five years the influence of the Faculty, as a State society, has begun to widen. The time has now come for a restoration of its larger functions and purposes as a State organization. The regular profession of the State should recall the past glory and authority of this venerable institution, and now come to its aid and support. Its present value to the profession is not fully appreciated; its future is full of possibilities for usefulness. Shall we continue to neglect such an influence or shall we enlarge and widen its scope and capabilities? Who will remain indifferent to such a cause? No physician in Maryland who loves his profession.

Prevention of Blindness in Infants.

THE enactment into a law of the bill "To Prevent Blindness in Infants," by the recent Legislature, is a matter worthy of more than passing notice. Since 1891 a committee, appointed by the Medical and Chirurgical Faculty, has been endeavoring to lessen the number of eyes lost from ophthalmia neonatorum. The members of this committee are Drs. Woods, Rohé, H. Friedenwald, and Michael, of Baltimore. At the request of these gentlemen, Dr. L. C. Carrico, of Charles county, a member of the Senate, introduced a bill early in the session, requiring that any swelling of the lids or mattering of the eyes in an infant under two weeks of age, be at once reported to a physician, and that the nurse, midwife or other attendant, shall use no remedy for the eyes.

The bill easily passed the Senate, but met considerable opposition in the House. Eventually it passed on the day before adjournment with the amendment that no "medicinal" remedy be applied by the midwife or nurse. A penalty of fine or imprisonment is attached for violating the act. The Governor has signed the bill. Maryland is the fifth State in the Union to enact such a law. New York, Rhode Island and Maine have had it for some time. This year Ohio and Maryland have fallen in line.

Two objections brought against the measure, while pending, were: Can the law be enforced, and do physicians, as distinguished from oculists, know how to cure the disease? Regarding the first, undoubtedly some cases may escape; but if the eyes are lost, sooner or later the child will find its way to an eye hospital or an oculist's office. In such cases it will not be specially difficult to trace the neglect to the responsible party. Again, children brought for treatment before the eyes are injured, may have been kept away for several days after the disease had appeared.

The object of the law is to teach midwives to report cases at once. An arrest of one of them will be an excellent means of education. Until the Faculty meets we do not know just what plans the Committee may have for enforcing the law. But we want to urge every physician to tell the midwives and nurses the wants of the law and of its importance; to investigate either indirectly or with the committee cases of its violation.

Regarding the second question, Can all

physicians treat the trouble properly? a little self-examination is in order. We think ophthalmia neonatorum is a disease whose treatment no medical man has a right not to know. Exceptionally a case may be incurable; but such a case is very exceptional. Of eyes lost, neglect or bad treatment can be found in the large majority. A disease so serious as to receive special legislation in five States demands attention from every practitioner.

* * *

A Home for Epileptics.

THE efforts of the King's Daughters and Sons of Maryland to establish the "Silver Cross Epileptic Home" in this State should receive the heartiest encouragement of the entire medical profession.

The evolution of certain philanthropic movements is a most interesting feature of our civilization. Why public sentiment should have been aroused in certain directions and should have accomplished such magnificent results, while other equally needy conditions of society have been almost entirely ignored, is a question of social development which we cannot here discuss.

It is, however, true that the epileptic has not received the consideration from society or the State which his condition demands.

One of the oldest and at the same time one of the most notable philanthropies for the relief of the epileptic is the colony referred to in Dr. Sanger's letter.

The annals of Christianity of the century now nearly at an end will contain no brighter record than that of the great work of pastor von Bodalschwingh. This broad-minded man saw the great necessity of an institution which would be the means of establishing a place for the epileptic in our social system; he recognized also, that the epileptic must have a home where he could be sheltered from the tyranny of conditions calculated to aggravate his trouble, that this sort of a house established upon an industrial plan would not only constitute a very important feature of treatment, but would at the same time afford the best opportunity for such observation and study as would increase our knowledge of the therapeutics of this disease.

Started in a very moderate way about thirty years ago, the colony has grown until in 1892 it contained over 1200 patients; a veritable industrial army where more than thirty different callings are pursued by men and many by women.

From 1867 to 1887, 2407 cases were treated, out of which 157 were cured, or about six and one-half per cent.; 450 were improved. Very happily, as a result of the example of this noble charity, other similar institutions have sprung up in Germany, Holland, Switzerland and other parts of the world.

In 1890, Governor Campbell, of Ohio, appointed a Commission to select a site and prepare plans for an institution for epileptics in that State. A year later the corner stone was laid. The board of managers of the California Home for the care and training of feeble-minded children at Santa Clara, have provided a separate pavilion for epileptics, and interest is being manifested in many other States.

It is to be regretted that the bill mentioned in a former number of the JOURNAL, to form a Special Commission to investigate the subject of the care and colonization of epileptics in this State, which was introduced into the last Legislature, should have failed to become a law.

The work which the King's Daughters have undertaken will, however, receive the sanction of society, and must in time meet with the approval and, it is hoped, the financial support of this State.

OBITUARY.

DIED on the 11th inst., at the residence of his father, in the 34th year of his age, Dr. HENRY MERRYMAN WILSON, JR., of Pueblo, Colorado. Dr. Wilson was graduated from the University of Maryland, and after several years of general practice here determined to devote himself to throat and nose diseases in Colorado, in which he was eminently successful. He was specialist to the Denver and Rio Grande Railroad, and member of the Climatological and various local societies. His professional contributions were valuable, and to his patients and friends his politeness, gentleness and integrity will long remain as a pleasant memory.

MRS. JULIA BALLARD WALTON, of Annapolis, wife of Dr. H. R. Walton, died in that city last week, after a short illness.

BOOK REVIEWS.

A TEXT-BOOK OF DISEASES OF THE EAR AND ADJACENT ORGANS. *By Dr. Adam Politzer*, Imperial Royal Professor of Aural Therapeutics in the University of Vienna, Chief of the Imperial Royal University Clinic for Diseases of the Ear in the General Hospital, Vienna. Translated into English from the third and revised German Edition, by OSCAR DODD, M. D., Clinical Instructor in Diseases of the Eye and Ear, College of Physicians and Surgeons, Chicago. Edited by *Sir William Dalby, F. R. C. S., M. B.*, Consulting Aural Surgeon to St. George's Hospital, London. In one large octavo volume of 748 pages, with 330 original illustrations. Cloth, $5.50. Philadelphia: Lea Brothers & Co.

Sir William Dalby, in the editorial preface to this book, says: "As a treatise on diseases of the ear it is complete, since it embraces all that is known on the subject." If this opinion is incorrect we are not able to point out its error. Dr. Politzer has added to otological literature a book no aurist can afford to be without. He discusses with candor and with no attempt to dogmatize the subjects most and least known. Nothing is slurred. Save that this edition follows the same general plan, the book is not specially like preceding editions. It is practically a new book. Modern pathology is given due recognition.

There is, too, a conciseness in this, characteristic of the preceding edition. The first one hundred and sixty-two pages are devoted to anatomy, physiology and methods of physical examination of the organ of hearing. Considerable importance is attached to the tragus, concha and various curves in the auditory canal as sound-conducting elements, more important than most authors assign to these structures. Here, as everywhere, the writer says why he thinks as he does. He thinks tuning forks of various keys essential to diagnosis. One naturally turns to the chapter on recent therapeutic measures, the operative treatment of adhesive aural processes and suppurative diseases. One with conservative tendencies will not find himself disposed to rush into operative work after reading Dr. Politzer's discussions. As regards adhesive processes, generally speaking, he thinks that none of the procedures he describes can be depended on to give good results, that the therapeutic effect of the various operations depends on pathological conditions, the diagnosis of which, before operation, is far from easy and not always possible; that the results, as regards hearing and subjective noises, is usually temporary—"permanent only in isolated cases;" that there is always risk of doing harm. At the same time he thinks the whole subject is a proper field for investigation, and results so far recorded justify and demand further study. In this connection he specially mentions Dr. Jock's operation for removing the stapes. He thinks the field for operative work larger in suppurative disease, and more promising, especially for the improvement in hearing after the cure of suppurative otitis media. An excellent and novel feature of the book is an index of literature of eighteen pages, classified in subjects and not containing the works quoted in the text proper. The publishers' work is, of course, excellent.

SYSTEM OF DISEASES OF THE EAR, NOSE AND THROAT. Edited by Charles H. Burnett, A. M., M. D. VOL. II. Philadelphia: J. B. Lippincott Company.

Vol. I contained descriptions of diseases of the ear, nose and naso-pharynx. This volume concludes the diseases of the nose and naso-pharynx and contains in addition those of the pharynx and larynx. It is fully up to the standard of Vol. I, reviewed in the JOURNAL some months ago. Among the writers of this volume are Seiler, Jarvis, Bosworth, George M. Gould, J. Lewis Smith, Lennox Browne, and J. Solis-Cohen. Dr. Smith writes of diphtheria. He gives minute directions concerning the precautions the physician should take against infection for himself and others. Gargling or sponging the throats of well members of the household with peroxide of hydrogen, 1 to 10, and the nose with a 1 to 15 solution, is recommended. The whole body of the well children should be bathed with an antiseptic solution; a mixture of oil of eucalyptus, carbolic acid and turpentine should be allowed

to simmer constantly near the patient to disinfect "the air exhaled in the breath and arising from his surface."

Another interesting and instructive chapter is by Dr. Gould on the interdependence of nose and eye diseases. Dr. Jarvis gives the surgical procedures used in nasal troubles with clearness. He speaks of the necessity of antisepsis in nasal operations, and of the comparatively greater liability of sepsis after operations upon the septum. He does not mention what seems to us a source of infection after nasal operations, no matter how antiseptically the work may be done, *i. e.*, absorption from the surfaces around the operative field. We have observed, after cauterization of the septum, chills and elevation of temperature lasting several days; "post-operative manifestations" which, he says, are no doubt septic.

A Laboratory Guide in Urinalysis and Toxicology. By R.A.Witthaus, A.M.,M.D., Professor of Chemistry and Physics Medical Department University of the City of New York; Professor of Chemistry and Toxicology in the Medical Department University of Vermont; Member of the American Chemical Society and of the Chemical Societies of Paris and Berlin, etc., etc. *Third Edition.* Oblong 12mo., interleaved, one colored plate, 102 pages. Muslin, price, $1.00. New York: William Wood & Co., 1893.

This is the third edition of an excellent laboratory guide, former editions of which have already been noticed in these columns. There has been added in this revision a system of qualitative analysis. The book is divided into chapters on General Rules, Manipulation and Analytical Reactions, Qualitative and Quantitative Analysis of the Urine, of Urinary Deposits and Urinary Calculi, and a Detection of the Mineral and Vegetable Poisons. It is bound in a convenient manner for laboratory work and has blank pages interleaved for additional notes.

George Keil, 1715 Willington Street, Philadelphia, announces the early publication (third edition) of the "Medical and Dental Register-Directory and Intelligencer," for the States of Pennsylvania, New York, New Jersey, Maryland and Delaware. It will present not only a complete list of all medical and dental practitioners in the States named, with place and date of graduation, but also lists of professional educational institutions, hospitals, societies, etc., and will be of much practical value to all members of these professions.

MEDICAL ITEMS.

The Maryland College of Pharmacy held its commencement this week.

*

Governor Brown, of Maryland, turned down the dentist's bill, because of its incompleteness.

*

Dr. William Osler, of the Johns Hopkins Hospital, will spend the summer abroad.

*

The twelfth International Medical Congress will be held at St. Petersburg, Russia.

*

The third triennial meeting of the Congress of American Physicians and Surgeons will be held at Washington, D. C., May 29 to June 1, inclusive.

*

The Committee of Arrangements of the American Medical Association announces that rates to the meeting next month at San Francisco have been reduced one-half.

*

Dr. Henry B. Wilson, of Boonsborough, Maryland, and formerly resident physician at Bayview Hospital in this city, has established a very successful practice at Omaha, Nebraska.

*

The Baltimore Medical College, Baltimore University School of Medicine, University of Maryland, College of Physicians and Surgeons, and the Southern Homœopathic College, held their commencements during the past week.

*

All the bills which were favored by the Medical and Chirurgical State Faculty were passed by both Houses of the Maryland Legislature and have been approved by the Governor.

Dr. Robert C. Rasin has closed his office at 413 N. Charles St., this city, and is now located at 600 W. North Avenue.

*

On account of the destruction by fire of the largest hotel in Gettysburg, the Medical Society of the State of Pennsylvania will not hold its annual meeting there, as recently announced, but at Philadelphia.

*

The Middleton Goldsmith Lecture of the New York Pathological Society will be delivered by Professor William H. Welch, of Baltimore, on Saturday, April 28, in the hall of the New York Academy of Medicine, on the subject of Mixed and Secondary Infections.

*

The Board of Governors of the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore has purchased property adjoining their present building on East Baltimore Street, to make room for the increased numbers of patients to be treated.

*

Senator Hubner's bill to provide for the establishment of another insane asylum in Maryland has become a law, with the amendments that it shall not be located on the Eastern Shore and cutting down the size of the farm from 500 acres to one of not less than 250 acres.

*

Dr. Israel J. Woodward, who stood first in his class at the Baltimore University School of Medicine, has been appointed resident physician at the Baltimore University Hospital, vice Dr. Thomas Craig, who has left for his home in New York State to enter on the practice of medicine.

*

The Pure Food Bill, which provides against the sale or possession of impure, adulterated, sophisticated or unwholesome milk, fish, fruit, vegetables, meat or any other food products kept fresh by salicylic or boracic acid, or any other preservative, has been referred to the Committee on Health of the Baltimore City Council.

It is announced that a Miss Blanche Blake, a medical student in the Woman's Medical School in London, recently passed third in honors at the Bachelor of Science examination of the University of London, with marks qualifying for a gold medal. This is the highest place of the kind yet attained by woman.

*

There is a very praiseworthy attempt being made by the friends and relatives of the late Dr. John W. Branham, late assistant surgeon U. S. Marine Hospital Service, who died of yellow fever at Brunswick, Ga., to obtain an appropriation from Congress for his widow and two children who live in Baltimore.

*

Dr. and Mrs. George H. Rohé, of Catonsville, Md., will sail for Europe on the 28th inst., to be absent about three months. Dr. Rohé goes as the official delegate from the American Association of Obstetricians and Gynecologists to the Berlin Society of Obstetricians and Gynecologists at its fiftieth anniversary; he will also look into the construcuction and management of insane hospitals generally.

*

At the City Hospital, Baltimore, the following changes have been made: Dr. C. F. Blake, resident physician, vice Dr. Standish McCleary; Drs. E. H. Wood, John Ruhruh and John Briscoe respectively first, second and third assistants; at Bayview Hospital, Dr. H. H. Haydon, resident and Dr. C. W. Laciar assistant resident physician; at the Maternité, Drs. A. S. Hotaling and A. T. Gundry; and at Spring Grove Asylum, Dr. T. A. Councell.

*

Ground was broken this week for the erection of the Woman's Fund Memorial building of the Johns Hopkins Medical School. It is to be finished by November 1, 1894. The building will contain dissecting rooms, chemical research, histological and embryological laboratories, a photography room, directors' rooms, macerating room; an embalming room, and a crematory for burning refuse. It will be used exclusively for anatomical purposes.

BUSINESS DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

The safest mode of remittance is by bank check or postal money order, drawn to the order of the *Maryland Medical Journal*; or by Registered letter. The receipt of all money is immediately acknowledged.

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TO PRACTITIONERS OF MEDICINE.

The Medical Law as repealed and re-enacted, with additions and amendments, by the Maryland State Legislature, has been printed at this office in neat and convenient form for physicians. Copies may be obtained at the Journal Office or will be forwarded by mail on receipt of 15 cts. in stamps or coin.

THERAPEUTIC NOTES.

SANDER, in the *Therapeutic Gazette*, says that Alumnol is not, in his experience, a specific for gonorrhœa.

*

TREATMENT OF BURNS IN CHILDREN.—Wertheimer, says a cotemporary, treats burns in children by first thoroughly washing the injured part with luke-warm boric-acid solution. Over this is placed absorbent gauze which has been soaked in lime-water and linseed oil, each 50 parts; thymol, .05 to .10 parts. This is placed over the raw surface in the form of broad strips, is covered in with absorbent cotton, and is held in place by a moderately firm gauze bandage. The dressing should be renewed every day. By the end of the second week the following ointment is employed :

℞.—Bismuth subnitrate, 9 parts;
Boric acid, 4.5 parts;
Lanolin, 70 parts;
Olive oil, 20 parts.

This is applied on absorbent gauze strips as was the first mixture. Internally, stimulants are administered.

*

Sajous' Universal Medical Journal recommends for seasickness, chlorobrom, 4 to 6 drachms, divided so that one teaspoonful may be taken every five minutes.

READING NOTICES.

Celerina and Aletris Cordial, equal parts, teaspoonful every four hours, will relieve ovarian neuralgia.

*

Leucorrhœa is, according to Professor Louis Bauer (Royal College of Surgeons, England), Professor of Principles and Practice of Clinical Surgery, St. Louis College of Physicians and Surgeons, often due solely to constipation, hence clearance of the bowels of their fecal contents is in many cases the chief and most effective treatment of that troublesome disorder.

In properly adjusted doses, perhaps the mildest, simplest and most efficient of all laxatives or aperients is, the Elixir Six Aperiens, (Walker-Green's). One advantage the Aperiens has is, it does not tend to leave the bowels in a confined state and the dose does not need to be increased, but diminished.

*

Habitual Miscarriage.—A. B. Barnette, M. D., Cruntytown, W. Va., says: I have used Aletris Cordial in one case where the lady miscarried in four successive pregnancies and in the fifth I gave her Aletris Cordial, and it acted like a charm. I carried her through safely to full time. I don't think there is anything to equal Aletris Cordial in such cases. I think it is just the medicine we want.

*

Fermentative Dyspepsia.—For this form of dyspepsia Professor Austin Flint prescribes bismuth subgallate, in ten grain doses, either in capsules or tablets, three times daily after eating. If constipation exists, he recommends the use of Villacabras water, giving before breakfast enough to produce two or three evacuations; for two or three days after a daily movement follows. The water may then be repeated, if necessary.—*Brooklyn Med. Jour.*

*

Messrs. I. O. Woodruff & Co., the well known dealers in physicians' specialties, have removed from 88 Maiden Lane, New York, to 106-108 Fulton Street. This firm has occupied their old quarters for the past ten years, but owing to the increasing demands of their business have sought a new location, affording every facility for the prosecution of their extensive business. When writing,, we should be pleased to have physicians state their experience in the use of Messrs. Woodruff & Co.'s specialties. Correspondents will always receive prompt and courteous attention from these gentlemen.

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ORIGINAL ARTICLES.

THE EXTINCTION OF TUBERCULOSIS.

THE PRESIDENT'S ADDRESS BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 24, 1894.

By George H. Rohé, M. D.,

President of the Medical and Chirurgical Faculty of Maryland; of the American Association of Obstetricians and Gynecologists; Professor of Therapeutics, Hygiene and Mental Diseases in the College of Physicians and Surgeons of Baltimore; Superintendent of the Maryland Hospital for the Insane, Catonsville, Md.

THIS Ninety-Sixth Annual Convention of this Faculty should be to us an occasion of congratulation. During the past year our losses in membership have been few, and our gains not inconsiderable.

The semi-annual meeting held in Annapolis last November was very successful in point of attendance as well as in the character of the work accomplished.

In an address at the opening of that meeting, I said: "A legitimate object of organization is to use it as a power to secure legislation. Not legislation for our benefit as physicians, but legislation for the public good. The medical profession wants nothing for itself from the Legislature. The legislation in which the profession is interested is such as will be for the benefit of the whole people. Public health laws, medical registration laws, lunacy laws, were all intended for the good of the public, although always originated, and their enactment promoted, by the efforts of physicians."

It gives me especial gratification to call your attention to some recent results of such organization in this State. During the last session of the General Assembly three measures were considered in which the medical profession were interested, and which had their origin in committees appointed by this Faculty. These measures were: The Amendment of the Medical Practice Act, the bill for an Additional Hospital for the Insane, and the Act for the Prevention of Blindness in Infants. Each of them passed in essentially the shape in which it was recommended by the Faculty through its appropriate committees. Having watched the progress of these measures through the Legislature, I believe I may say that not one of them would have passed in satisfactory form if the members of the Legislature had not been impressed by the fact that the organized profession of the State, as represented in this Faculty, endorsed and supported them. In this connection I may be permitted to mention a circum-

stance which, I think, justifies this statement. When the bill for the prevention of blindness was put upon its passage in the House of Delegates there was a good deal of opposition to some of its provisions. The bill was eloquently and intelligently defended by the Baltimore City delegation and the Committee on Hygiene, but the opposition was so determined that for a time its success was problematical. It was not uninteresting to note that the only effective opposition came from those counties which are still unrepresented in this Faculty.

There is additional reason for congratulation in the fact that all the labor of getting a law passed through the Legislature was not rendered nugatory by unfavorable executive action, as has happened to the profession of this State heretofore. Having at present in the executive chair a Governor "noted for his common sense," as was happily said by Dr. Preston, in the discussion on the Care of the Insane at Annapolis, all our bills have been approved and are now laws.

These successes should only render more forcible the appeal of the Committee on Membership for a larger representation of the profession of the State in the Faculty. There is room in this organization for every honorable regular practitioner in Maryland.

I will now invite your attention to some considerations showing the possibility of

THE EXTINCTION OF TUBERCULOSIS.

For over two thousand years a portion of the medical profession has believed in the contagiousness of consumption. A not inconsiderable proportion of the laity has likewise leaned to this view. So strong was this belief at one time that toward the close of the eighteenth century a law was promulgated in the kingdom of Naples, making very stringent regulations looking to the registration of consumptives, the segregation of the sick in hospitals and the destruction of infected articles. It seems that at the beginning of the present century the prevalence of consumption in Southern Italy was so great that the expression, "See Naples and die," could almost be taken in its literal sense.

About thirty years ago Villemin demonstrated the communicability of tuberculosis by a series of experimental inoculations upon animals. The results obtained by this investigator were soon confirmed by Chauveau and others. It was, however, not until the epoch-making discovery of the tubercle bacillus by Robert Koch, in 1882, that the value of the researches of the two distinguished French experimenters was generally recognized. Since that time the view that tuberculosis is an infectious and communicable disease has gradually pervaded the profession until to-day there are probably few physicians laying claim to common sense and current knowledge who would attempt to controvert it.

Coincidently with the general acceptance of the infectious nature of tuberculosis have come experiments to more definitely indicate the common methods of infection, and endeavors to restrict the disease within narrower limits. That this is a laudable striving must be conceded when we reflect that the annual mortality from tuberculosis in its various forms in the United States is 163,500, or nearly 450 per day; and that in this city the deaths from consumption of the lungs alone reach nearly twelve hundred per year, a ratio of 13.69 per cent. to the total mortality. If the deaths from tuberculosis in its various forms were included, the ratio would amount to over fourteen per cent., or one in seven, which is the ratio throughout the world, as stated by Koch in his memorable paper announcing the discovery of the bacillus tuberculosis.

In accepting the infectious nature of this disease, we must not overlook the influence of the receptive condition of the individual in determining the time or place of infection. While the value of hereditary predisposition in determining phthisis is often over-estimated, we cannot ignore it altogether; neither may we undervalue the effect of an acute or chronic inflammation, a traumatism, or other weakening factor in rendering the

tissues less resistant, or more receptive to the infective agent. These and many other conditions governing the infection of the individual must be recognized and accorded their full worth. The essential fact remains, however, that without the inoculation of the bacillus tuberculosis we cannot have consumption, or any form of tubercular disease; and if by any means we can exclude this infective agent from the body the individual is safe from the disease.

There are two principal channels of infection in tuberculosis; one is by the digestive tract and the other, far the more important, by the respiratory organs.

Children are especially liable to infection by way of the digestive organs. An infant nursed by a consumptive mother, or one fed on milk from tuberculous cows, may become tuberculous if the food contains the infective agent. It has been shown that the milk may contain tubercle bacilli, even though there is no recognizable local tubercular disease of the lacteal glands. It is highly probable that the frequency of tuberculosis of the intestinal canal, the peritoneum, the mesenteric glands and other abdominal organs in the young, is in most cases attributable to direct infection by tuberculous milk. In the adult this avenue of infection is likewise open. Meat from tuberculous animals, or other articles of food accidently contaminated by the tubercle bacillus, may be the medium of communication. Secondary infection, from swallowing the bacillus-laden sputum from the lungs, is also not infrequent.

I need hardly say, however, that in the great majority of cases of tuberculosis the infection takes place by way of the respiratory organs, which also become the principal, and generally the only, seat of the disease.

It is held by some, and I am inclined to consider the belief well founded, that the tubercle bacillus cannot effect a lodgment in the tissues and begin its destructive action, unless these are weakened in their resistive power by an inherited defective organization, or by acquired conditions of lowered vitality. It is a result of clinical observation that a catarrhal pneumonia, for example, is often a forerunner of pulmonary consumption. It is assumed, with good reason, that the anatomical elements of the lining membranes of the inflamed air-cells and finer bronchial tubes succumb to the attacks of the invading germ, carried in the inspired air, while in a state of health the tissues could resist the destroying organism. This simply emphasizes the importance of avoiding any factors tending to depress the vital condition of the organism or any of its parts.

The tubercle bacillus does not multiply under ordinary conditions outside of the body, and the fully developed organism when removed from the conditions favoring its growth in the body soon loses its vitality. But the spores of the bacillus, or the germs of the germ, as one may say, are extremely resistant and retain their power of growth and development for a considerable period. The dried spores are thus always potential sources of mischief, if accidentally taken into the system by inhalation or swallowing. They may also be inoculated in wounds or traumatisms, but this mode of infection is comparatively rare, and may be left out of account in the present discussion.

Careful investigations by Baer and Cornet have shown that the death-rate from consumption is four times as great in German prisons as among the free population of the same age. In convents, asylums, and similar institutions, tubercular diseases are also extremely prevalent. In the Maryland Hospital for the Insane, over thirty per cent. of the deaths are due to tuberculosis. I am confident that within the last two years at least three patients contracted the disease by infection in the wards. Efforts have been made recently to minimize this danger.

Dr. Lawrence F. Flick has shown by a patient and laborious study of the cause of death in the fifth ward in the city of Philadelphia, that certain houses in that ward are infected. He found that for a period of twenty-five years, from 1863 to 1887, all the deaths from tuberculosis in the ward occurred in less than

one-third of the houses, while in 1888 over one-half of the tubercular deaths occured in these same houses, demonstrating beyond a doubt that these houses were infected.

I can hardly think it necessary to adduce proof that the tubercle bacillus is in all cases of tuberculosis the active agent of the infection. Recent investigations, especially those of Cornet, have shown the manner in which infection occurs. The breath of consumptives contains no bacilli, and is not infective. Even when the lungs are full of broken-down tissue swarming with bacilli, the latter are only in the rarest instances, if at all, exhaled in the breath. Of course, during a fit of coughing, small particles of pus and secretion containing bacilli may be carried along in the forcible expulsion of air from the lungs, but even this is probably rare. Ordinarily the air of rooms or of hospital wards occupied by consumptives is free from bacilli and may be breathed with impunity. It is only when the dust of the room, containing dried and pulverized sputa, is disturbed by sweeping, or shaking up the bed-clothing, or in other ways, that danger of infection occurs. Scrapings from the walls of rooms occupied by consumptives, inoculated into animals, produced tuberculosis in twenty per cent. of the latter. Control experiments showed that dust from the walls of houses, hospital wards and public buildings not inhabited by tuberculous patients was not infective. Cornet showed also that the dust from the walls was in no case infectious when sputum cups were used to receive all expectorated matter, although such expectoration was full of bacilli. Praussnitz has demonstrated the presence of tubercle bacilli in the scrapings from the interior of railway carriages on one of the German railway lines carrying many consumptive passengers. Thus is experimentally demonstrated a danger to which attention had previously been forcibly drawn by Whittaker, Gihon and others.

It is generally agreed among physicians that if the stools from a case of typhoid fever are disinfected before being thrown out where they may contaminate the drinking-water supply, there is little if any danger from further infection. The alvine excreta being recognized as containing the infective agent, the destruction of the latter renders the material innocuous. In like manner it may be accepted as demonstrated by recent researches that if the sputa of a case of consumption be disinfected as soon as expectorated the consumptive patient is no longer a source of danger to his neighbor.

From the foregoing it becomes evident that the principal measures of prophylaxis against tuberculosis must be such as comprise, first, immediate destruction of the bacillus tuberculosis in the sputa, or in other excretions when the case is not a pulmonary one; second, the disinfection of clothing and bedding, or other furniture liable to be contaminated with the infective material. As accessory measures, must be considered notification to the health authorities of all cases of consumption, public disinfection of infected houses and conveyances (ships, railway cars), and the establishment of special hospitals for the free treatment of indigent consumptives.

The first example of an attempt at a thorough-going restriction of tuberculosis is the decree of the king of Naples in 1832, before referred to. According to De Renzi, quoted by Flick, this decree contained the following propositions:

1. The physician shall report the consumptive patient, when ulceration of the lungs has been established, under penalty for the first offence of 300 ducats, and upon repetition, of banishment for ten years.

2. An inventory shall be made by the authorities of the clothing in the patient's room, to be identified after his death, and if any opposition shall be made, the person doing so, if he belongs to the lower class, shall have three years in the galleys or in prison; if to the nobility, three years in the castle and a penalty of 300 ducats.

3. Household goods which are not susceptible shall be immediately cleansed and those that are susceptible shall at once be burned or destroyed.

4. The authorities themselves shall

tear out and replaster the house, alter it from cellar to garret, carry away and burn the doors and wooden windows and put in new ones.

5. The sick poor shall at once be removed to a hospital.

6. Newly built houses cannot be inhabited before one year from their completion, and six months after plastering has been finished and repairing has been done.

7. Superintendents of hospitals must keep in separate places clothing and bedding for the use of consumptives. Other severe penalties are threatened to those who buy or sell objects which have been used by consumptives, to servants, members of the family, and to any transgressors whomsoever.

The discovery of the bacillus tuberculosis and its mode of propagation and transmission would almost seem to justify these harsh regulations. Indeed, their enforcement appears to have produced a marked reduction in tuberculous diseases. Dr. Flick, who has made a very thorough study of this question, estimates that in 1782 the mortality from tuberculous diseases in the kingdom of Naples was ten per thousand of population. In 1887 the official statistics for the Italian States formerly comprised under the Neapolitan Kingdom showed that the death-rate from all forms of tuberculosis was only 2.05 per thousand living people.

The efficient carrying out of restrictive measures against consumption requires intelligent coöperation on the part of the public. Hence, the education of the laity upon the infectious nature of tuberculosis and the importance of individual measures of prophylaxis must precede any successful enforcement of legal enactments looking toward the restriction of the disease. There can be no doubt that the public press can give most effective aid in spreading such knowledge. The newspapers are always foremost in the dissemination of useful information. The press is the most powerful auxiliary of the sanitarian. The press makes public opinion. Public opinion makes laws, and until laws have the sanction of public opinion, it is futile to look for their successful enforcement.

Popular societies, like the French "Ligue préventive contre la phthisie pulmonaire," and the "Pennsylvania Society for the Prevention of Tuberculosis," are also useful and effective agencies in educating the people upon this subject. The organization of similar societies should be encouraged elsewhere.

Our current knowledge of tuberculosis and its means of prevention was effectively summed up in a report made to the New York City Health Department in the early part of 1889, by Drs. T. M. Prudden, H. M. Biggs, and H. P. Loomis, the pathologists of the department, and extensively published. In 1890, the Prussian Government issued a set of regulations which admirably cover the whole subject. This action was followed by the kingdom of Wurtemberg in 1892. In the same year the State Board of Health of Michigan issued a pamphlet giving instructions for the disinfection of sputa, and in 1893 the same Board went a step farther and adopted a resolution requiring consumption of the lungs and other tubercular diseases to be reported among "the diseases dangerous to the public health," this report to be made by householders and physicians to the local health officer as soon as the disease is recognized. The purpose of such report is to secure to the health officer information of the location of each case, "with the view of placing in the hands of the patient reliable information how to avoid reinfecting himself or herself, or giving the disease to others, and in the hands of those most endangered, information how to avoid contracting the disease."

The publication of the report of Drs. Prudden, Biggs and Loomis seems to have been the first official notification to the public by any health authority of the infectiousness and preventability of tuberculosis, since the Neapolitan decree before quoted. Within a few months the New York Health Department has taken a more aggressive step, and now requires "all public institutions, such as asylums, homes, dispensaries, etc., to

transmit to the Board of Health the names and addresses of all persons suffering from pulmonary tuberculosis within seven days of the time when such persons first come under observation." Physicians are requested to notify the Board of all cases coming under their professional care. Hospital authorities are urged to separate consumptive patients from those sick of other diseases. Special inspectors are appointed to visit the residences of consumptives, deliver printed instructions containing methods of prevention, and practice disinfection when required. One of the municipal hospitals is to be set aside as a "Consumptive Hospital" for the exclusive treatment of this disease, and whenever requested by physicians, the Health Department will undertake the bacteriological examination of the sputum in doubtful cases.

Action in a similar direction was contemplated by the Board of Health of Philadelphia, but objection on the part of some physicians to the compulsory notification of the disease was so strong that it has been for the time abandoned.

Within two months the State Board of Health of Washington has placed consumption among the diseases required to be reported to the Board.

The Board of Health of the city of Baltimore is about issuing a circular to the public, giving suggestions in reference to preventive measures against tuberculosis.

The Pan-American Medical Congress, in session in Washington last September, adopted resolutions recommending to the various National Governments represented, effective measures for the restriction of the disease, and the American Public Health Association, which has been studying the question for the past four years through a special committee, set its stamp of approval upon the work of the committee, by the adoption of the following report and recommendations in Chicago last October:

1. "Tuberculosis has been conclusively demonstrated to be contagious, by bacteriological experiments, by clinical observations, and by a study of the history of the disease.

2. "Tuberculosis is a preventable disease. Its preventability follows as a logical sequence upon its contagiousness, but has likewise been demonstrated in practical life.

3. "The contagium of tuberculosis resides entirely and solely in broken-down tubercular tissue. A person suffering from tuberculosis, therefore, does not become a source of danger to others until he begins to give off broken-down tubercular tissue, either in the form of sputa from the throat or lungs, diarrheal discharges from the bowels, or matter from a tuberculous sore such as lupus, white swelling, cold abscess, scrofula or tubercular inflammation of a joint.

4. "*A person suffering from tuberculosis can be made entirely harmless to those about him by thorough sterilization of all broken-down tissue immediately upon its being given off. With proper precautions it is therefore possible to live in the closest relation and upon the most intimate terms with consumptives without contracting the disease.*

5. "Tuberculosis is not hereditary. A predisposition to the disease can be transmitted from parent to offspring, but this is more true of tuberculosis than it is of all other contagious diseases.

6. "A predisposition to tuberculosis can be created anew by malnutrition or by anything which depresses the nervous system.

7. "Tuberculosis affects animals as well as man, and is identically the same disease in both. In domestic life human beings and animals mutually infect each other.

8. "The media through which human beings are ordinarily infected by animals are milk and meat.

9. Houses in which consumptives have lived and in which immediate sterilization of all broken-down tissue has not been practiced, are infected houses and are liable to convey the disease to subsequent occupants.

10. "Spitting upon floors and into handkerchiefs, and permitting the broken-down tissue to dry and become pulverized, is a prolific cause of spreading tuberculosis.

11. "Temporary occupation of hotel

rooms, sleeping-car berths and steamer cabins by consumptives in the infectious stage can infect them so as to convey the disease to subsequent occupants, unless proper precautions are taken against contamination of the bedding, furniture and walls with broken-down tubercular tissue.

"We recommend the following practical measures for the prevention of the disease :

1. "The notification and registration by health authorities of all cases of tuberculosis which have arrived at the infectious stage.

2. "The thorough disinfection of all houses in which tuberculosis has occurred, and the recording of such action in an open record.

3. "The establishment of special hospitals for the prevention of tuberculosis.

4. "The organization of societies for the prevention of tuberculosis.

5. "Government inspection of dairies and slaughter-houses, and the extermination of tuberculosis among dairy cattle.

6. "Appropriate legislation against spitting into places where the sputum is liable to infect others, and against the sale or donation of objects which have been in use by consumptives unless they have been thoroughly disinfected.

7. "Compulsory disinfection of hotel rooms, sleeping-car berths and steamer cabins which have been occupied by consumptives, before other persons are allowed to occupy them."

The City of London Hospital for Diseases of the Chest, the North London Hospital for Consumption, the Royal National Hospital for Consumption, the National Sanitarium, the Manchester Hospital for Consumption and the Victoria Dispensary for Consumption, issue instructions to be observed by their patients to prevent spreading the disease. These all comprise the use of spit cups, disinfected cuspidors, the prohibition of expectorating on the floor indoors, or on the ground out of doors, and the avoidance of swallowing the sputa to prevent reinfection.

In the various sanatoria for tuberculosis in Germany and in many in this country similar instructions are issued. Some progressive private practitioners in this country have had cards printed containing concise instructions for the disinfection of sputa, and other measures to prevent the further spread of the disease.

The various practicable measures for the restriction of tuberculosis may be summed up as follows :

1. Notification to the health authorities of all cases of tuberculosis, more especially of tuberculosis of the lungs. This report should be made by the physician who becomes cognizant of the case in the line of his professional duty, and by the householder himself. In order to reach all cases, such notification should be compulsory. While it is probable that some cases would escape report through the negligence or wilful disregard of the medical attendant, these would be few and would diminish as soon as the benefits accruing from attention to this regulation became apparent.

2. All public institutions, as hospitals, prisons, schools, asylums, etc., should be required to promptly report through their managers or executive officials, under penalty, all cases of tuberculosis occurring in such institutions.

3. Upon the recovery, death or removal of a consumptive from one house or apartment to another, notice should be given by the patient or his guardian, the householder or the physician, to the health authorities, in order that appropriate measures of disinfection of the vacated premises may be taken.

4. Concise instructions for the guidance of patients with pulmonary consumption, or persons coming into frequent contact with them, should be furnished free of charge by the health authorities, upon notification of a case, or at the request of any person interested. These instructions should cover especially the means for destroying or rendering innocuous the sputa. *The isolation of patients is not necessary; when the material containing the tubercle bacilli—in these cases the sputa—is destroyed, the con-*

sumptive is no longer dangerous to his most intimate associates.

5. The health authorities should be empowered to employ special inspectors to visit all cases of consumption reported, instruct the patients themselves and the family, or those brought closely and constantly in contact with them, in the best means of avoiding self-infection and the communication of the disease to others, and to disinfect the apartments occupied by the consumptive if found necessary. It may be objected that this will interfere too much with the rights and privileges of the attending physician, but the latter would doubtless often be willing to be relieved of the tedious details necessary. There could, of course, be no objection to the attending physician performing these duties himself, provided they were thoroughly done.

Neither the inspector nor any other officer of the health department should be allowed to comment on the physician's treatment or to offer any suggestions in this particular. I believe it will be generally conceded that sanitary officials conduct themselves with tact and discretion in their relations with physicians.

6. Municipalities should be urged to establish special hospitals for the treatment of indigent consumptives. General hospitals should provide special wards for patients with this disease, and enforce in them the proper measures for the limitation of infection.

7. Railway and steamship companies should be required to change and disinfect all bed-linen and other materials liable to infection from consumptive travelers.* Dr. Albert L. Gihon, in an address before the Pan-American Medical Congress, has graphically referred to the danger in steamship travel with consumptives, and Dr. J. T. Whittaker has pointed out the many sources of possible infection in the Pullman car.

Such are, in outline, some facts and suggestions that I have thought not inappropriate to present to you on this occasion. The facts are vouched for by leading investigators, physicians and sanitarians. The suggestions are legitimate deductions from the facts recorded. No one who studies the question without prejudice can resist the conviction that tuberculosis, "the great white plague," is a preventable disease; that by concerted action on the part of physicians, sanitary authorities and the public, it can be stamped out among all civilized peoples; that, like leprosy and the black death, it should be of interest in the future merely to the historian of human progress.

*It is reported that on one of the Hungarian railway lines special railway cars will be furnished for consumptives. These will be renovated and disinfected after each trip.

THE ETIOLOGY AND PATHOLOGY OF HEMORRHOIDS. — The unsatisfactory causes that have been assigned for the production of hemorrhoids have led Dr. Samuel T. Earle (*Mathews' Medical Quarterly*, April, 1894) to perform some experiments on the lower animals, and as a result he found that both arteries and veins take part in the etiology of hemorrhoids and the inflammatory condition of the vessel walls with their hyaline degeneration was most probably brought about in man by the long continued pressure of the feces. The sphincter which is ordinarily intended to keep closed the orifice of the rectum shuts around the hardened feces and the muscle is kept in a state of active contraction, constricting the vessels and causing a local increase in the blood pressure resulting in the inflammatory change mentioned. Varicose vessels in other parts of the body may help, but the retained feces are the principal cause. Still a hemorrhoid is not simply a varicose condition of one or more veins, but it is also an increase in the connective tissue surrounding the walls.

THREE CASES OF LEFT INGUINAL COLOTOMY.

Read Before the Philadelphia Academy of Surgery March 5, 1894.

By John H. Packard, M. D.,

of Philadelphia.

By some surgical writers, notably the elder Gross, the opinion has been expressed that the making of an artificial anus by opening the colon placed the patient in a condition so distressing that death itself would be preferable. My own experience with these operations warrants me in upholding a very different view. My first case occurred in 1873, and I had the advantages of the presence and assistance of Prof. Gross and of Dr. Levis; the patient, whose rectum was occluded by a uterine cancer, lived in comfort for eight months, dying then from exhaustion due to the advance of the disease. In this instance, and in other cases for many years afterward, I made the opening in the left loin, thinking the access more ready, and preferring to avoid encroaching upon the peritoneum. There is, however, one great objection to the method, that the point of exit for the feces is so placed as to be only with difficulty reached by the patient, and to require the assistance of others in attending to it.

For the operation in the left groin, I think the best rule as to the incision is to make it just as on the right side in appendicitis, an inch and a half from the left anterior superior iliac spine, and at right angles with a line between this process and the umbilicus. With scrupulous asepsis the opening of the peritoneum is made with safety; the operation is one of no more difficulty than that in the loin, and the artificial anus is entirely under the patient's control. The directions given in some of the books for the finding of the bowel seem to me to be needlessly complex; if the large intestine does not immediately present itself in the wound, a portion of the small intestine will, and must be pushed aside, when the sigmoid flexure, especially if distended, will be seen, and may be recognized by the longitudinal muscular bands.

My own opinion is that it is a matter of but little moment whether the bowel is opened at once or after the lapse of several days.

I do think it important that the gut should be well drawn down into the wound until the portion above this point is slightly tense, so as to avoid subsequent prolapse through the artificial anus. Even with this precaution it sometimes happens that the inner wall will pouch out and be a cause of some annoyance.

For suturing the edges of the peritoneum to those of the skin it is well to use black silk, so that these stitches may be readily distinguished from those by which the bowel itself is fastened in the wound; these latter should be of white silk, and should penetrate beyond the muscular coat, but not through the mucous membrane.

It is not always easy to judge how large an opening should be made into the bowel. In a child, or when the wall of the gut is very thin, a small orifice will suffice; and I do not think more than three-quarters of an inch is ever necessary.

Case I.—James Brewster, a mulatto, aged fifty-five years, but looking much older, was admitted into my ward at the Pennsylvania Hospital, November 26, 1892, on account of epithelial cancer of the rectum. His condition was most deplorable; there was a mass of disease stiffening the wall of the bowel and discharging from its ulcerated surface a very offensive pus, which, mixed with fecal matter, flowed away constantly through the wide-opened anal orifice. Hence he not only suffered agonizing

pain, but the intolerable fetor made him loathsome to himself as well as to all about him.

He had, moreover, a left inguinal hernia, which he ascribed to the kick of a horse in January, 1891. This did not in any way interfere with the operation, which was done four days after his admission. The opening into the bowel was not made until December 4, or four days later.

Immediately after the operation his temperature fell to 97.6°, but he soon rallied and did well. The artificial anus gave no trouble, but was cleansed once daily. By means of washing out with a solution of potassium permanganate or other detergents, the rectum was rendered inoffensive. A portion of the diseased mass was curetted away about four weeks after the colotomy, but no more radical procedure seemed to be justified.

The patient lived in comfort until April 18, nearly five months, and then died painlessly from exhaustion.

At the autopsy it was found that the morbid growth extended five inches above the anus, and had involved the posterior wall of the bladder; there were abundant deposits in the pelvic and mesenteric glands.

A somewhat noticeable fact was that the serous covering of the gut was adherent to the parietal peritoneum for a long distance above the point of operation.

Case II.—Ellen Black, aged fifty-two years, was admitted under my care in the Pennsylvania Hospital, October 24, 1893, suffering from extensive cancerous disease of the uterus, involving the rectum; she had not had a natural stool for a year. Her general health was not greatly impaired, but she had a great distress by reason of the rectal obstruction.

The next day I exposed and secured the sigmoid flexure, and twenty-four hours afterward opened the bowel. Just after the operation her temperature fell to 96.2°, but reaction took place quickly. Regular movements were soon had through the artificial anus, and on the seventh day she was discharged at her own request, to return to her home in Sullivan county, Pa.

Case III.—Mrs. M., aged about fifty, living in one of the cities in the interior of this State, was seen by me in April, 1893, on account of almost total obstruction of the rectum by the pressure of a tumor of the womb, which filled up the entire pelvic cavity. To attack this in its then condition seemed to me, as well as to her physicians, unwarrantable; and as her suffering arose mainly from the rectal obstruction, I proposed opening the bowel in the left groin. To this she agreed, and I performed the operation at her residence. Complete relief was afforded, and after some experiments in the devising of a suitable contrivance for keeping control of the contents of the bowel, this lady was enabled to resume her active life, going into society freely, and attending to all her affairs without hindrance.

Should this tumor, probably a fibroid, develop so as to rise out of the pelvis, the question of hysterectomy might be entertained; and if this were successfully accomplished the closure of the artificial anus might, perhaps, be undertaken.

DISCUSSION.

Dr. J. M. Barton: I can speak most favorably of inguinal colotomy. It gives us an opportunity of determining what portion of the bowel is involved and making our opening well above the disease. It also permits us to explore the glands in the interior if removal of the rectum is contemplated. In regard to opening the bowel I have preferred to permit it to remain at least four or five hours before opening; by that time the peritoneal surfaces are adherent. It has been recommended to leave the bowel twenty-four hours and then open with the Paquelin cautery. This seems unnecessary. I usually employ scissors and control any bleeding that may occur with hemostats. I have had no difficulty from prolapse.

Dr. John B. Deaver: It has fallen to my lot to have done several colotomies, but only one or two inguinal. My reason for preferring the lumbar method is chiefly that it is an extra-peritoneal operation. Another reason is that if the disease extends it will take longer to

reach the opening in the loin than one in the abdominal wall in front. I am free to confess that I have been largely influenced by the views of Mr. Bryant. The lumbar operation is not by any means difficult. I think that it is quite as simple, and where there is distention, simpler than the abdominal operation. In the anterior operation distention increases the difficulty.

The anterior wound can probably be looked after better than one in the loin, but it is more difficult to keep a pad in position in the former case.

Dr. T. S. K. Morton: Not many days ago I did an iliac or inguinal colotomy, and a most curious feature of the case was an apparent transposition of the colon to the right side. On making the incision in the left side the colon presented, but on making traction it was found that the entire transverse colon and omentum was speedily delivered, and I had considerable difficulty in locating the descending colon. I finally traced it to the right inguinal region. The lumbar operation I think would not have been feasible in this case.

There is one point which I think has not been sufficiently emphasized, and that is the importance of making a spur. This cannot be done by suturing the side of the bowel to the abdominal opening. If little pieces of feces pass the opening and reach the diseased surface they cause a great deal of pain. I have seen nothing equal to a bar of glass or other material passed through the meso-colon for securing an adequate spur. When the bowel is cut transversely upon this support you have two openings presenting, one above the other, and it is impossible for feces to pass across. As far as the control of the anterior opening is concerned in the cases that I have seen it has been almost perfect.

With regard to prolapse, Mr. Allingham has proposed dragging into the wound as much colon as possible and removing the redundant portion; he claims that this will prevent subsequent prolapse. This method has been condemned by others and it has been found sufficient to make the upper part of the colon taut before fixing it.

The size of the opening I think should be the entire diameter of the bowel. This gives some sphincter-like action to the end. It has occurred to me that we might employ here the operation of Gersung for incontinence of feces from the anus; that is, rotating the bowel a full circle before suturing it. It has been shown that where incontinence is present an efficient sphincter can be made in this way and one that will control liquid feces.

Dr. John B. Roberts: A limited experience with both operations leads me to strongly favor the inguinal method. I feel, with Dr. Morton, that the important thing is to obtain the spur. I do not see how that can be easily done without using some form of support and bringing the mesentery out of the wound. I think it a most important feature. I prefer, where it can be done, to wait a few days for adhesions to take place. In opening the bowel I am inclined to prefer cutting entirely across.

Dr. Packard: With regard to the making of a spur, it has never been necessary in any of my own cases, and I think it can only exceptionally be of advantage. If the opening made is sufficient the feces will escape easily through it, and the lower part of the bowel has been, in my cases, kept quite free from irritation by them. Of course if a spur is to be made the bowel must be drawn clear out.

As stated in the report of my cases, there was, in the third especially, still some tendency to prolapse in spite of the drawing down of the bowel, and I should be glad to know of some other way of preventing it.

I am aware that Allingham advises the complete section of the bowel, but it seems to me to add to the gravity of the operation without adequate advantage.

A properly adjusted pad ought to keep its place without trouble.

CARASSO, in the *Gazzetta degli Ospitali*, reports 39 cases of consumption treated with success by continuous inhalations of peppermint oil, and creosote, glycerine and chloroform, with a one per cent. solution of peppermint oil internally

SOCIETY REPORTS.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

61ST REGULAR MEETING.

The President, Dr. Thomas A. Ashby, in the chair.

Dr. Thomas Opie reported THREE RECENT ABDOMINAL OPERATIONS.

Case 1.—Mrs. B., aged 45, admitted to the City Hospital October 18, 1893, suffering from uterine fibroids. Abdominal hysterectomy was performed October 25. Patient was discharged November 22, 1893.

From the family history of this case, it appears that a sister died from an ovarian cystoma, which had not been operated on. We learned from her personal history that she began menstruating at eighteen. From this time she worked hard on her father's farm until twenty-five years of age, when she was married. After bearing six full-term children she ended her faithfulness with a miscarriage. Up to this time she had enjoyed uninterrupted health, save woman's usual embarrassment, constipation. During five years past, however, her life has been a series of tortures. Dysmenorrhea and menorrhagia were peculiarly distressing at her periods. Severe cramps were realized in the right side of the abdomen which extended down the right leg. Constipation was ever present. Appetite poor. Bladder very irritable. She stated that she was confident she often passed her water fifty times in a night, and when she resisted the prompting during the day or night a deathly nausea came over her. Sexual indulgence was never painful except during a few days preceding the menstrual function.

There was nothing noteworthy in the operation. During four or five days after it, she repudiated every kind of food save small quantities of buttermilk. The abdominal sutures were removed on the ninth day. The urine could not be passed naturally until the thirteenth day. A letter received from her a week since informed me of her enjoyment of excellent health. I submit the womb, which was removed as stated. It serves as an apt illustration of the three forms of uterine fibroids, viz.: subperitoneal, intra-mural and submucous. The first variety is shown in the specimen, at the junction of the body and the neck. The second is exemplified in numberless small fibroids, scattered throughout the walls of the body and neck of the uterus. The third is a submucous fibroid tumor, the size of a guinea-egg, attached by a pedicle and occupying the cavity of the body of the uterus.

CASE II.—M. J., aged 37. Admitted to City Hospital November 15, 1893. Diagnosis: Large multiple fibroid mass on the left side, encroaching upon the liver and a second tumor, cystic in character, occupying a lower position on the right side of the abdomen. According to the history given us of her case, the catamenia began at thirteen years of age, and was regular during seventeen years. At the age of thirty, therefore, she is said to have contracted a severe cold at her period and afterwards had a complete suppression of her flow until one year ago, when severe hemorrhages set in, which lasted on an average three weeks at a time. The patient had noticed an abdominal enlargement for the past six years, which gradually grew larger. In the meanwhile, when at 33 years of age (four years ago), she married. During the past four months she has been a sufferer from nausea, diarrhea and dyspepsia. Her size has been that of the full term of pregnancy. The operation, supra-abdominal hysterectomy, was performed November 17, 1893. The abdominal incision having been made and the fibroid and cystic elements having been confirmed, the patient was turned to the left side, the cyst was opened with the knife, when the flow of amniotic fluid and blood announced the fact of pregnancy. The operation was proceeded with. There was no hemorrhage. The pedicle gave no trouble, indeed it presented the neatest appearance after closure of the flaps and all betokened as good a result as any case of hysterectomy I had ever performed. The fetal devel-

opment showed the pregnancy to be about four and a half months advanced. On the day following the operation, the patient had rallied well, her pulse was steady and strong and the temperature normal. November 19, slight jaundice supervened. Emesis occurred, but was not troublesome. November 20, the jaundice had markedly increased, her pulse was rapid and weak; expression anxious and vomiting continuous. Death ensued at 11 P. M., forty-six hours after the operation.

The kidneys and liver presented at the post-mortem, held by Prof. Keirle, marked fatty change. The left lobe, which had been under pressure by the fibroid mass on the left side, was pale and anemic, giving strong contrast with the right lobe, neither being normal. Was this an attack of acute septicemia, or was there obstructive jaundice here, which brought about the fatal result?

Case III.—B. C. S., aged eleven years; a school girl. Was admitted to Baltimore City Hospital. Her parents first observed an enlargement of the abdomen more than four and a half years ago. There is no history of menstruation, nor has she ever had an accident or serious illness. She has always enjoyed good general health, although she has not been able to study hard or regularly at school. For the last three months she has complained of pain in her (stomach) abdomen. During two years she has had some headache and dizziness. Tapping had been resorted to twice; each time one-half ounce of yellow fluid is said to have been withdrawn. When first examined by Drs. Thomas, Bailey, Chambers and myself, the abdomen was distended by a large, fluctuating tumor, which completely filled up the abdominal cavity. The prevailing opinion of the examiners was that the case was either hydatids of the liver, ovarian cystoma or a kidney cyst. When the patient was upon the operating table in the dorsal decubitus and under anesthesia, by partially raising her with the hand under her back, so that only the shoulder and sacrum rested on the table, it was perceptible that the tumor was not a pelvic one, since it gravitated away from this region. Moreover, percussion gave a continuity of dullness over the liver and the tumor. Upon opening the abdomen a large unilocular cyst was found resembling an ovarian cystoma both as to the wall and fluid contents. It was attached to the base of the liver between the gall-bladder, which was incorporated in the sac wall on the left side and the spigelial, caudate and right lobes. No definite pedicle could be made out. The sac was punctured and the contents, all of which were fluid, emptied, and the sac stitched into the upper part of the wound, the superfluous portion having been cut away. A large gauze drain was inserted along the tract of the collapsed sac. It has now been over six weeks since the operation was performed. The wound is still open and the probe can be inserted up to the attachment of the sac to the liver. There is still a continuous, clear discharge amounting to about four ounces in twenty-four hours. The child's general improvement is very pronounced. Her mother states that she has never known her to look so well. Nevertheless, the sac, which has been constantly washed out with the bichloride and a solution containing equal parts of tincture of iodine and carbolic acid, continues to elaborate its secretion. Prof. Keirle found Drysdale's corpuscles in the fluid taken at the time of the operation from the sac.

Dr. B. B. Browne mentioned a case in which the child was delivered by a midwife. Subsequent examination by Dr. Browne showed the presence of a large-sized fibroid, but as involution progressed the tumor became smaller, until only a small knot remained.

Dr. T. A. Ashby mentioned a case in his own experience, in which a woman aborted several times, this being apparently due to the pressure of a fibroid.

Dr. Ashby also showed a uterus with multiple fibroid, which he had removed that morning.

Dr. J. Edwin Michael reported the following case of Sudden Death After Labor.

Mary Axman, colored, aged 28, was

in labor when admitted. Upon examination, child was found to be transverse. The os was fully dilated, membranes intact and patient was in fair condition. No history as to how long patient had been in labor. The contractions of the uterus were hard and long and came on at intervals of three or four minutes. She was admitted at 4.30 A. M. and was allowed to go on until 7 A. M., when it was decided to do internal podalic version. Patient was put to sleep with chloroform, membranes ruptured and a large amount of amniotic fluid escaped. Patient put in an exaggerated lithotomy position, right hand of operator introduced and came in contact with hands of fetus, which were pushed up out of the way. Hand passed to the left and breech felt and the left or anterior leg caught and brought down to os. Right leg could not be reached with right hand, so left was introduced and passed along posterior uterine wall and right leg found folded back on dorsum of child. It was brought down and then both feet were pulled through vulvar orifice.

Owing to the slippery condition of the child's feet and exhaustion of the operator, sufficient traction could not be made to turn the child. A piece of bandage was passed around the left foot and traction made and child turned, easily giving the position of r. s. i. a. Steady traction was then made and breech easily delivered. Both hands were caught up over the head and were delivered with some difficulty. Head delivered by Veit-Smellie method with some difficulty. Uterus contracted well and expelled the placenta spontaneously. Operation occupied one hour. Patient seemed in fair condition, with pulse and respiration good. While vaginal douche was being given, patient suddenly lost pulse at the wrist and respiration slowed. The anesthetic was stopped and three hypodermics of whiskey given, which improved her. Next, uterine douche was given and foot of bed elevated. Hypodermic of sulphate of strychnia, gr. 1-30, ergotole *m.* xxv, hypodermically; this followed by a hypodermic of 1-100 grain of nitro-glycerine and whiskey. Limbs bandaged to hips. Hot bottles applied. Patient now being conscious, was given hot coffee and whiskey every fifteen minutes. Patient then moved to another bed and another hypodermic of nitro-glycerine, 1-100 grains; whiskey and sulphate of strychnia, gr. 1-50, was also given. Later hypodermic of ergotole, *m.* xxv. Patient complained of pain in the legs, and a want of air and wanted to turn on her left side. Pulse became more slow and weaker, respiration less frequent, patient more pallid and died at 9.35 A. M., one hour and thirty-five minutes after the operation. Post-mortem showed uterus intact, kidneys white and fatty, intestines bleached and lungs pale. Baby was dead when delivered and weighed nine pounds and twelve ounces.

This is the first case of the kind I have seen; they are quite rare. The post-mortem was of especial interest. Dr. Lawson, who did the work, is an experienced and competent man. I saw the case half an hour after the version was done. Everything was done that we thought could be of use to restore her. I was afraid that rupture of the uterus had occurred, but the post-mortem showed that it did not take place. The lungs were pale and bloodless, heart contracted, bloodvessels contracted and empty; the conditions which justified the conclusion of death by shock. There are cases in surgery in which there is shock severe enough to produce death where the traumatism is not so great as in labor. A number of cases have been recorded where the passage of a sound has caused death by shock. So the surprise is that we do not have more cases of death from shock.

Eight causes of sudden death after labor are mentioned by Parvin in a paper upon that subject:

1. Mental shock. 2. Result of severe pain. 3. Diseases of the heart: *a.* Laceration. *b.* Paralysis from over-distention. 4. Diseases of bloodvessels: *a.* Aorta, or *b.* Splenic vessels. 5. Accidents of labor: *a.* Post-partum hemorrhage. *b.* Rupture of uterus. 6. Pulmonary thrombosis. 7. Air embolism. 8. Respiratory difficulties due to diseases of the lungs, or pressure on the lungs.

These eight heads do not fully cover the ground. As I said in the beginning, we have the conditions of shock in obstetrics as well as in surgery ; and traumatism of the genital apparatus, both in male and female, seems especially liable to produce severe shock.

Dr. Thomas A. Ashby: Dr. Riley called for me recently to see a case of a patient who had lost very little blood, but she was in such profound shock that I thought she would not live ten minutes. It was the most profound shock I have ever seen. Abundance of whiskey and nitro-glycerine were all that rescued her. There was no lesion detected, only the shock from delivery.

WILLIAM S. GARDNER, M. D.,
Secretary.

MEDICAL PROGRESS.

TUBERCULAR PERITONITIS.—In giving his experience with tubercular peritonitis, Dr. T. J. Crofford (*American Journal of Obstetrics*, April, 1894), relates seven cases of various kinds which were not easy to differentiate before operation. In some the onset was sudden as in acute peritonitis, while in others it was slow and insidious. It has been mistaken for typhoid fever and gastric ulcer. Of the seven cases,all rallied and recovered from the operation; one died in the third week, probably from tubercular cirrhosis of the liver which had existed prior to the operation; one died in the seventh month. Four of the cases were in a very bad state at the time of the operation. As a result of the operations, four of these cases attended to their household duties and are enjoying life, one being entirely cured. From a study of these cases and the operations he concludes:

1. Tubercular peritonitis is an operable disease. 2. The immediate danger from the operation is not materially influenced by the character of the inflammation. 3. An early operation is of greatest value. 4. The chronic or slowly progressing variety offers the best indications for surgical interference. 4. When the primary deposit is in the tubes, which Winckel declares to be in fifty per cent. of the cases, an early salpingotomy will cure the disease. 6. Operations later in the disease will frequently prolong life and possibly cure.

* * *

DIET IN DIABETES.—At the Eleventh International Medical Congress, Dr. Saundby, in speaking of diet in diabetes, said that formerly it had been considered important to cut off the carbo-hydrates from the diet of diabetics, but that he would reverse this and give them carbohydrates as far as they could assimilate them. He began with a strict diet, excluding all sugar, starch, etc., and gradually allowed small quantities of potato, and such substances, watching the urine as a guide.

He found that such patients could take carbo-hydrates to a limited extent without harm and they were more apt to keep to such a diet than to one which excluded all such food.

* * *

EXPERIMENTAL SURGERY OF THE URETER.—Dr. Charles B. Penrose reports in the *University Medical Magazine* a case of a white woman with scirrhous cancer of the cervix. In the operation it was found that the left ureter passed directly through the cancerous mass and it was necessary to exsect about one inch of the ureter, which he did. Instead of bringing the renal end out through an opening in the loin, as recommended by most text-books, he implanted it in the bladder. The patient made a speedy recovery. This was like a case reported by Dr. H. A. Kelly, who, however, united the proximal and distal ends of the cut ureter with success. This takes a little longer, but is more satisfactory if the patient can stand it.

* * *

Physicians of Louisville are now compelled to pay a license of ten dollars a year. Thus the 340 physicians of that city hand over to the city treasury $3400 annually, and yet they are expected to give much of their time and skill to charitable institutions of this city. They wish to retaliate by charging the city for all charitable work.

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See Publishers' Department, Page 38.

BALTIMORE, APRIL 28, 1894.

EDITORIAL.

The Extinction of Tuberculosis.

IT is a very healthy sign of the times when municipal and State boards of health not only discuss with intelligence the prevalence and mortality of tuberculosis, but when they actually take practical and effective steps towards its extinction. When the people begin to recognize the contagious principle of tuberculosis and appreciate the importance of destroying it as it leaves the infected body, then, and then only, will cases of sickness and death from this dreadful disease grow less.

Familiarity with, and propinquity to, any disease, however fatal, makes one careless and callous; tuberculosis is always in our midst and has excited very little comment on the part of the people. If Asiatic cholera or small-pox should appear in this country and cause one-tenth the number of deaths that tuberculosis does, the whole country would be aroused to immediate action. As Dr. Rohé has shown in his forcible and timely address, so long as the expectoration and other infected excreta of the body are properly disposed of, the danger of carrying contagion is reduced to a minimum.

The rules which are laid down to prevent and lessen the spread of this disease may seem like hardships at first, but they are not difficult to carry out. Each physician and each householder should constitute himself a committee of one to see to it that all consumptives under his care or supervision follow the excellent rules laid down by Dr. Rohé in his address and reduce the chances of spreading the disease to the lowest point. It is only by this individual effort that the disease will be driven back and good results will come.

* * *

American Achievements in Surgery.

AMERICA, and more especially the United States, which has made progress in every way, has just reason to be proud of her achievements and successes in the domain of surgery. This Dr. George F. Shrady, the editor of the New York *Medical Record*, has set forth in a clear and popular way in the April number of the *Forum*. He mentions very naturally the discovery and use of ether in Boston, and the first steps in abdominal surgery by Dr. Ephraim McDowell, of Kentucky, who endangered his life in doing what his neighbors called a "dastardly experiment," which fortunately for him turned out a success.

During and after the civil war there were numberless opportunities which were quickly grasped by the active and alert American mind, for devising new operations, appliances and surgical treatment. Dr. Shrady has mentioned only some of the great works of surgery by Americans and while he could not ignore men like McDowell, Morton, Gross and others outside of his own city, his field of observation apparently lies principally in the city of New York.

In many ways the American mind is awake to possible inventions in any department, but it is also ready to make useful the inventions of less practical nations, and in this way surgical procedures were possibly first used here when their theoretical foundation was laid in other lands. The article is a pleasant one to read and shows what can be done in surgery with boldness, care and judgment.

THE attempt to find a universal language has not as yet met with success. Each nation is too jealous to give up its own, and while English is making steady advances, still at such a polyglot gathering as the International Medical Congress it was in a very small minority. Volapük started out with a great flourish and it did look at first as though it would be of great practical advantage as a means of communication between persons not understanding each other's language, but it was not of long life and similar artificial languages have shared a like fate.

A Universal Language.

Dr. Achilles Rose, of New York, makes a very strong plea in the New York *Medical Record* for the use of Greek as the international language of physicians. He means modern Greek and very properly lays great stress on the fact that Greek, unlike Latin, is not a dead language, but is in use by a large number of people. His point is well taken and he gives some very valuable hints on the study of language in general, but his suggestions will hardly meet with success. The number of physicians who speak, write and understand ancient or modern Greek outside of Greece must be very small.

It is by no means uncommon for physicians to understand French, German, and even Italian, and it is such that usually attend international meetings. The time is hardly ripe for an international language and when it does come it will be by gradual development or by a supremacy of one people over the others, and hardly by any artificially-constructed language like Volapük.

* * *

THE passage and approval by the Governor of Maryland of the amended Medical Practice Act, which regulates the practice of medicine in Maryland, is a great credit to the legislative body, to the Chief Executive of the State, and to the Medical and Chirurgical Faculty which has for many years been laboring for this end. The law in full with its amendments has been published and will be distributed to physicians and others who may desire it.

* * *

THE general opinion of the Eleventh International Medical Congress seems to be now that it was a big show with little results. The attendance was too large. The experience of the reception committee was too limited, and at the last moment everything was in unreadiness, so that a large number of delegates and visitors had great difficulty in finding a resting place. Such large bodies cannot but be unwieldy, and it only goes to prove that the "greatest show on earth" does not necessarily mean scientific work. Little good comes from international congresses of this kind unless small sections are held, and those in attendance have a thorough knowledge of the language used. Small, limited bodies generally give the best results.

* * *

THE tendency of some diseases to appear in cycles is once more shown in the return of small-pox, which is said to be assuming rather unpleasant proportions in Chicago, and other places. The one true and safe means of protection, effective vaccination, should be enforced in all cities before the disease makes too great headway. It is the duty of family physicians to insist that all families under their care be fully protected and the municipal authorities should also see that the vaccine physicians are faithful to their duties at this time.

OBITUARY.

DR. WILLIAM S. RICHARDSON, for many years one of the most prominent physicians of Harford county, died at his home in Belair last Monday afternoon, after a short illness. Dr. Richardson was born near Belair in 1830, his father being Major William Richardson. He was educated at the Belair Academy. He graduated in medicine at the University of Pennsylvania. Returning to Belair, he practiced medicine with his brother, the late E. Hall Richardson. Dr. Richardson leaves three sons, one of whom is Dr. E. Hall Richardson, and one daughter. He was a trustee in the First Presbyterian Church, Belair, and was a generous-hearted, hospitable and courteous man.

DR. SAMUEL F. POWELL, of Baltimore, died last week of heart disease. He was fifty-five years old, graduated at the College of Pharmacy in 1858, and in medicine at the University of Maryland in 1862.

BOOK REVIEWS.

UNITED STATES DISPENSATORY. Seventeenth Edition. Thoroughly Revised and Largely Rewritten. With Illustrations. By H. C. Wood, M. D., LL. D.; Joseph P. Remington, Ph. M., F. C. S.; and Samuel P. Sadtler, Ph. D., F. C. S. Philadelphia: J. B. Lippincott Co. Price, Extra Cloth, $7.00; Sheep, $8.00; Half Russia, $9.00. Thumb Index, 50 cents additional.

Previous editions of this enormous work have already been noticed in these columns. The numerous changes in the United States Pharmacopœia have made this new edition necessary. In Part I, there is a list of the remedies contained in the British and American Pharmacopœia. Part II contains the National formulary of unofficial preparations adopted by the American Pharmaceutical Association, with many formulas, and it contains also a list of drugs and preparations not official. Part III gives the tests, test solutions, weights, measures and sundry matters. The alterations are very great. Both the metric and old systems are used. There is a new index of diseases. It is a magnificent work and is a credit to the authors, who have spared no pains to make every part as full and complete as possible.

AN AMERICAN TEXT-BOOK OF THE DISEASES OF CHILDREN, including Special Chapters on Essential and Surgical Diseases of the Eye, Ear, Nose and Throat; Diseases of the Skin; and on the Diet, Hygiene and General Management of Children. By American Teachers. Edited by Louis Starr, M.D., Physician to the Children's Hospital, and Consulting Pediatrist to the Maternity Hospital, Philadelphia; Late Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc.; Assisted by Thompson S. Westcott, M. D., Attending Physician to the Dispensary for Diseases of Children, Hospital of the University of Pennsylvania; etc. Price: Cloth, $7; Sheep, $8; Half-Russia, $9. For sale by subscription only. Philadelphia: W. B. Saunders.

This text-book is very much on the style of Keating's Cyclopedia brought up to date. No fixed rule is given for the doses for children, but it is left to the judgment of the prescriber. Good, practical articles are those by Taylor on Massage and Exercise, and by Powell on Sea-air and Sea-bathing. In Osler's exhaustive article on Tuberculosis, he says in speaking of treatment: "Fortunately a large proportion of all cases of tuberculosis recover." This is more encouragement than most writers give. The article is illustrated with excellent colored plates. Miles, Latimer and Thayer, of Baltimore, all make valuable contributions to this work. The section on Asiatic Cholera, by E. O. Shakespeare, is particularly well worth reading. With but few exceptions, every department has been covered by specialists of experience, from whom much can be learned. The treatment in nearly every part is fully considered and numerous prescriptions are scattered through the text. The publisher and editor have issued a work which will be a standard for a long time to come. The glazed white paper reflects unpleasantly the light.

REPRINTS, ETC., RECEIVED.

Importance to the Surgeon of a Bacteriological Training; by Hunter Robb, M. D. Reprint from the *Johns Hopkins Hospital Bulletin.*

The Mechanical Treatment of Osteitis of the Knee; by Henry Ling Taylor, M. D. Reprint from the *New York Medical Journal.*

Some Reasons for the Performance of Circumcision on all Male Infants. By Alex. L. Hodgdon, M. D. Reprint from *American Medico-Surgical Bulletin.*

Maintenance of an Aseptic Technique in Gynecological Operations Outside of Hospitals. By Hunter Robb, M. D. Reprint from the *Johns Hopkins Hospital Bulletin.*

The Direct Examination of the Female Bladder with Elevated Pelvis. The Catheterization of the Ureters Under Direct Inspection, With and Without Elevation of the Pelvis. By Howard A. Kelly, M. D. Reprint from the *American Journal of Obstetrics.*

Modern Homœopathy; Its Absurdities and Inconsistencies. By William W. Browning, A. B., LL. B., M. D., Brooklyn, N. Y., Lecturer upon and Demonstrator of Anatomy, Long Island College Hospital, etc. Philadelphia: Press of Wm. F. Fell & Co., 1894.

The first number of the New York *State Medical Reporter*, published in Rochester, N. Y., and edited by Dr. H. Bronson Gee.

THE REFRACTIONIST, a journal of practical ophthalmology, intended to be an exponent of the Refraction world. Published monthly. Editor, Francis F. Whittier, A. M., M. D., Professor Clinical Ophthalmology, College of Physicians and Surgeons; Ophthalmic Surgeon St. Elizabeth Hospital; formerly on Resident Staff Manhattan Eye and Ear Hospital, etc. 74 Boylston Street, Boston. With associate editors. Subscription price, $2.00 yearly.

MEDICAL ITEMS.

Drs. Mary Sherwood and Lilian Welsh have sailed for Europe.

*

Small-pox seems to be unpleasantly prevalent in Chicago and other places in the West.

*

There are seventeen members of the medical class at the Johns Hopkins University.

*

Professor Mikulicz, of Breslau, will likely be chosen to succeed the late Professor Billroth in the Chair of Clinical Surgery at Vienna.

*

Up to the present, no action has been taken in the City Council of Baltimore to provide for public baths in this city during the heated term.

*

The *Union Médicale* states that M. Raymond has been elected a professor, to succeed the late M. Charcot, at the Paris Faculty of Medicine.

*

The Congress of American Physicians and Surgeons, which meets in Washington at the end of May, has every prospect of being more attractive than usual this year.

*

Among the Americans at the International Medical Congress, at Rome, were Drs. Geo. H. F. Nuttall, Thomas Flour and J. Hewettson, of Baltimore, the latter of whom read a paper there.

*

Dr. C. Sihler has resigned as professor of histology in the Medical Department of the Western Reserve University. Dr. Sihler was formerly connected with the Johns Hopkins University.

*

M. Leopold Hugo has founded a quinquennial prize of 1000 francs ($200) to be awarded by the Paris Academy of Medicine to the author of the best work on the history of medicine. The first award will be made in three years.

*

At the last meeting of the Philadelphia Pathological Society, on April 26, 1894, Dr. Simon Flexner, Associate in Pathology in the Johns Hopkins Medical School, delivered an address entitled, "An Experimental Study of the Nature and Action of Certain So-called Toxalbumins."

Miss Harriet Adams, a daughter of Judge F. G. Adams, of Kansas, has graduated in surgery from the State Medical College, and ranked above all the young men, taking first prize for the best commencement examination.

*

Dr. Robert B. Morison has been traveling in Italy this month, but purposely avoided the crowds and discomfort of Rome during the medical congress there. He has sailed from Genoa for this country in order to preside over the American Dermatological Society in May, at Washington, and after the adjournment he will return to Europe.

*

Dr. William Pepper has resigned as provost of the University of Pennsylvania after a long term of service, in which he has seen the University grow and develop to its present large size and great influence. Dr. Pepper will hold his professorship of medicine in the medical department, and will devote himself more especially to that school and the hospital.

*

The Board of Medical Examiners will hold its next examination on May 3. All physicians who have graduated since June 1, 1892, can only receive a license to practice in Maryland from this board. All physicians practicing prior to this date are compelled, before July 1, to register at the office of the Clerk of the Circuit Court of the city or county in which they live, and pay a fee of one dollar. Failure to comply with this regulation incurs a fine and imprisonment, or both.

*

At the meeting of the Medical and Chirurgical Faculty this week, the following officers were elected: President, Dr. Robt. W. Johnson; Vice-presidents, Chas. H. Jones and W. M. Nihiser; Recording secretary, Jos. T. Smith; Assistant secretary, Robt. T. Wilson; Corresponding secretary, Jas. M. Craighill; Reporting secretary, W. Guy Townsend; Treasurer, W. F. A. Kemp. Executive committee, Geo. H. Rohé, Wm. H. Welch, L. McLane Tiffany, David Streett. The president, recording secretary and treasurer are also members of this board. Western Shore Examining Board: S. T. Earle, G. Lane Taneyhill, Aaron Friedenwald, R. H. P. Ellis, W. E. Moseley, P. C. Williams, Hiram Woods. Eastern Shore Board of Examiners: W. F. Hines, B. W. Goldsborough, Monmonier Rowe, G. E. Dickinson, James Bordley.

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All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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The Index to Volume XXX of this Journal will be distributed to subscribers and others later.

NOTES.

A FRENCHMAN recommends treatment of typhoid fever by copious drinks of water. He says it is agreeable to the patient and very effective.

*

SODIUM SALICYLATE IN ACUTE RHEUMATISM.—When for any reason sodium salicylate cannot be given by the mouth in acute rheumatism, Lémanski gives it in the form of a suppository, fifteen grains, with enough coca butter to make it up. One to be used five or six times a day.

*

RUST stains may be removed, it is said, by washing the cotton or linen fabric, first in a solution of oxalic acid in water, four parts to eighty, to which fourteen parts of dilute hydrochloric acid have been added, and then wash well in cold water to remove all traces of the acid.

*

SINCE a Berlin pharmacist was murdered by a man who pulled the night bell and pretended he had a prescription to be compounded, all night callers in that city are compelled to wait outside in the night for their medicines. There is a recent agitation in Berlin to compel pharmacists to have suitable waiting-rooms for night callers.

READING NOTICES.

From C. H. Mastin, M. D., the most prominent surgeon in the South:—The Sennine which you sent me is a good combination for dry dressings. It is put up in a convenient form and I shall continue to use it to advantage.—Mobile, Ala., Feb. 29, 1894.

*

Dios Chemical Co., St. Louis, Mo. Gentlemen.—I received your Sennine and have been treating catarrh of long standing; the benefit I have derived is simply immense. I believe it will cure any catarrh. Respectfully, T. B. McClure, M. D., Memphis, Tenn., March 1, 1894.

*

J. A. Cullom, M. D., Crandall, Texas, says: I have used Papine, and am highly pleased with the results. I have several patients, subject to severe attacks of neuralgia and migrain, who cannot use morphia or opium on account of their distressing after-effects, such as extreme nausea and prostration. Papine acts like magic, relieving the excruciating pain, and there is no nausea or prostration following. I find a combination of Papine and Bromidia, equal parts, given in teaspoonful doses, to act like a charm in those cases of hysteria which call for an opiate, in combination with the bromides. Bromidia alone is the ideal hypnotic, and I get grand results from it in all cases of nervous irritability and hystero-epilepsy. It is my sheet-anchor in all cases of convulsions, depending on or caused by irritability of the nervous system.

*

Antikamnia.—This is a combination of elements belonging to the coal-tar group, and is an American product. It is a white crystalline powder, odorless, and has a slightly burning taste; soluble in hot water and in diluted alcohol, but not in cold water. It acts as antipyretic, analgesic and anodyne. The importance attached to this drug, I think, is due to its anodyne and analgesic power, and the celerity with which it acts. As an antipyretic in fevers, it acts more slowly than antipyrin, but is not attended with as much depression of the cardiac system and cyanosis. Whenever a sedative and analgesic together is indicated, this remedy meets the demand. In severe headaches it is the remedy *par excellence*.—C. A. Julian, M. D., Louisville Medical College, in *N. C. Med. Jour.*

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ORIGINAL ARTICLES.

PREDISPOSITION TO PHTHISIS.

THE ANNUAL ORATION DELIVERED BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 26, 1894.

By James T. Whittaker, M. D.,

Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medical College of Ohio, Cincinnati.

TURN where we may in the practice of medicine, we have to face Tuberculosis. Laënnec declared in his day that more than one-third of the patients in the hospitals of Paris were affected with phthisis. That was seventy-five years ago. Six years ago Cornet extended the number with the declaration that at least one-third of all mankind are, or have been, affected with tuberculosis. Cornet did not include in this statement bone and joint diseases, skin and gland affections, and the various hidden depots of the disease. Though they underestimated its frequency, the old masters did not err when they spoke of tuberculosis as the scourge of the human race, and we may hear the appeal of the later authorities all the way down from Louis, who wanted the various governments of Europe to unite in a crusade against it, to Koch, who, at the International Congress at Berlin, invites the nations of the earth to vie with each other in the study for means of relief.

To be more exact: In 4250 successive autopsies made in Breslau last year, gross macroscopic lesions of tuberculosis were found in 1393, that is, in one-third of all the cases on the post-mortem table. Boltz, of Kiel, found 424 cases in 2576 autopsies. Biggs found characteristic lesions in the lungs alone in sixty per cent. of his autopsies; Brouardel in seventy-five per cent. of his cases at the Paris morgue, and as many cases show only fine lesions and others recover without lesion, it is evident that it is scarcely possible to overestimate either the frequency of the disease or the variety of its manifestations.

Tuberculosis, as we know, may attack any body and any organ of the body in any or every grade of mildness and malignity.

Why does tuberculosis kill one man, spare another, and run a benign course in a third?

Because, we say, one man is more predisposed than another to suffer attack.

Is it really this predisposition, or is it a paraphrase; is it a fact or a word?

What is meant by it?

Not climate, or altitude, or dryness, or soil, or environment; not difference in the cause in quantity or character. The term is elastic, but it is never extended to include anything more than intrinsic cause.

Disposition is defined as a defect in

the constitution of an individual which lessens his resistance, and thus makes him more liable to invasion of the disease.

It is understood at the start that it is not a question of liability or immunity of different animals to the same disease. Different animals differ so much that we are warned against any interchange of blood in the operation of transfusion. It is a question of the same animal, and with us here, of man. Moreover, predisposition here does not mean increased liability to any disease, but to one particular disease, to-wit: to phthisis.

Pfeiffer makes the position plain by an example from ophthalmology. It has long been known that eye-strain produces myopia. The condition is seen to increase with increasing study, or strain, and is aggravated by bad light, bad atmosphere, bad health, etc. But with all this, the fact remains that under the same conditions certain individuals are affected in various degrees of intensity, and certain others escape entirely.

Many ingenious theories have been invented and proposed to explain this anomaly. Finally Stilling found that in myopic individuals the roof of the orbit is comparatively flat. Thus the insertion of the superior oblique muscle is dislocated to make the change of shape in the eyeball upon which the myopia depends. But myopia develops only in those individuals when they are subjected to eye-strain. These individuals are said, therefore, to be predisposed to myopia. The anatomical anomaly is the predisposition to myopia.

Is there, in this sense, a predisposition peculiar to phthisis? Köster finds it as Hippocrates did before him, in the paralytic thorax, which permits the easier colonization and multiplication of bacilli at the apices of the lungs. Such apices receive no fresh air at all. They inspire only gases and bacteria from other parts of the lungs. We have, he says, not so much to combat the bacillus as the disposition, that is, the build of the thorax, etc.

Wolff declares also that the danger of infection, at least in adults, is of far less importance than the danger of the disposition. He goes so far as to maintain that when an individual becomes tuberculous, it is useless to investigate the past for the occasion of the infection. Infection may reach far back into childhood. Klebs is a decided advocate of a certain disposition as a necessity to tuberculous infection, and Hiller emphasizes the fact to such extent as to say that it is not so much a question of infection with tubercle parasites as of the presence of an individual bodily predisposition. If a man has this predisposition, he says, what would it avail to keep the bacilli out of his lungs for a certain time? When we consider the universal distribution of them, we must recognize that in such an individual infection is a mere question of time. The treatment, therefore, is not the treatment of the disease, but the combat of the individual tuberculous disposition. From this standpoint, Volland asks, "How shall a man protect himself from consumption?" The only proper answer is, he says, that a man protect himself as much as possible from acquiring the disposition. For those in whom the condition has occurred in childhood, this advice is too late.

These authorities all assume it, but, aside from the paralytic thorax mentioned, no one of them attempts to define the disposition in any way.

Sometimes this disposition is said to be acquired, sometimes it is inherited. With the subject of inheritance, the question of disposition takes at once a wider range. May not the disease itself be inherited, that is, may not the tubercle bacillus be directly transmitted to the offspring? This question necessitates at once a revision or readjustment of definitions. It shows at once a misconception of the term and a confusion of disposition with causation, for a direct transmission is not a disposition. It is the disease itself, and if transmission be true in all cases, it renders any study of predisposition superfluous. Even though latent, we do not say of a child born with syphilis that it is born with a disposition, but with the disease itself. Hence the question of direct transmission by heredity must be disposed of first.

Goldsmith says that man first gapes with wonder at the mysteries about him and it is only when he ceases to wonder that he begins to study and observe. During the wonder period he has the credulity of a child and his mind is satisfied with any explanation. It suffices at first to be told that the universe was created. As for tuberculosis, it was inherited.

With our immediate forefathers it was assumed, as the easiest explanation, that tuberculosis was always inherited. The only question with them was as to the degree of the descent, or of the relationship included. From what we know of the universality of the disease, we know that it is always possible to find phthisis somewhere in the ancestry. The proportion widens of course with extent of relationship included. Thus, of the 1010 cases at the Brompton Hospital, including only parents, the report shows an average of 24.4 per cent. Cotton's 1000 cases, including parents, brothers and sisters, gave 36.7 per cent. Fuller's 385 cases included grandparents, uncles and aunts, and furnished about 60 per cent., and so on. But nowadays, outside of comic opera, we do not reckon inheritance from uncles, cousins and aunts. Williams estimates from his 1000 cases an average of 12 per cent. for direct hereditary predisposition, and 84 per cent. for what he calls family predisposition. Would anybody now seriously contend for inheritance of a disease from outside cause from grandparents? Attention may here be called to the fact that while 43 of his cases had the father alone infected, 67 had the mother alone affected, and 224 had brothers and sisters affected with the disease. Surely this fact speaks stronger in favor of infection than heredity. The trouble with heredity is that it does not explain enough. It is admitted that of 100 cases affected with phthisis, 12 or 24 will have had tuberculous parents, but if we recall the fact that these 100 patients had 200 parents, it will be seen that these numbers represent heredity in but one-sixteenth, or one-eighth of the cases, whereas we know already that tuberculosis is fatal in the lungs alone to one-sixth or one-seventh of mankind. We say of cancer sometimes that the role of heredity appears in eighteen per cent. of cases, not enough to make it merit consideration. We speak of the eloquence of figures. That depends upon what we want to prove. We forget sometimes that a figure is also a mode of speech. "One may prove anything with figures," is a proverb; and when we speak "figuratively" we intend to represent something else. Tallyrand said: "Si c'est un mensonge c'est les chiffres." But so far as figures speak here they prove nothing for the heredity of tuberculosis.

Advocates of heredity find support in the fixation of the disease in families. Thus Riffel declares that the families of two villages in Baden showed the disease more than one hundred years. Riffel made, as Langenhausen made before him, regular genealogical trees of families affected with tuberculosis. It is thus shown that where tuberculosis had once occurred in a family, it fixed itself with tenacity and remained up to the present time, following members of it relentlessly to extinction. Neither distance nor the introduction of healthy individuals upon the old trunk have sufficed to bar the descent of tuberculosis to posterity. The influence of the inherited disposition continues, he declares, even if a generation escapes attack. In fact, it suffices, as many examples show, to introduce one individual, hereditarily affected, though he may himself not be tuberculous, into a previously healthy family, to introduce the disposition to the entire posterity.

This author goes further. "It is remarkable," he says, "that a husband, himself from a healthy family, introduced into a family notoriously predisposed by inheritance, does not himself succumb to tuberculosis, but he may see fade before him his wife, children and grandchildren under the disease." Men who pursued this train of thought reached the conclusion of Riffel, that the tubercle bacillus is not the producer, but is only the attendant of tuberculosis.

Another factor in support of inheritance is the predominance in children

of gland, bone and joint affections, recesses of the body not open to direct invasion from the outside, and reached only through the avenue of the blood and lymph channels. Scrofula is certainly much more frequent in childhood, but scrofula is an outside disease. It is just under the skin and in the line of the lymphatics from the throat. Disease of the bone and joints in the earliest life, that is in the earliest weeks and months of life, are far more frequently due to syphilis than to tuberculosis. Hip joint disease, white swelling of the knee, Pott's caries, creations of tuberculosis, almost never show themselves in the first months, and rarely in the first years of life. Nevertheless it is true that tuberculous bone and joint affections are most common in later childhood. Here, however, may be mentioned the discovery of Schede that many of the intensely chronic rheumatisms of old age are often tuberculosis.

The advocates of inheritance also claim tuberculosis of the skin as a hematogenous infection, but surely this should have been the last resort, for the skin is the very outside and lupus is almost never found in conjunction with any internal deposit.

When we come to the scientific study of inheritance of a disease produced by a distinct cause, we observe that the subject falls at once into two divisions, to wit: Transmission at conception, that is with the spermatozoid or ovum, and inoculation later in intra-uterine life from an infected mother. Sometimes these divisions are differentiated as conceptional or germinative, and congenital, but these terms are so often used synonymously, or the latter for both, as to lead to confusion. It must be at once admitted that there is no way of ascertaining whether a fetus was infected in the ovary or in the uterus, so that positive proof of absolute inheritance can be adduced only from the side of the father. As for congenital tuberculosis, *i. e.*, infection from the mother, it is not only possible, but proven, but only as the great exception, not so often, for instance as in the case of small-pox.

Max Wolff inoculated a number of pregnant animals with tuberculous matter, and a second set of animals before they become pregnant. These experiments were not favorable to the view of transmission of the bacilli. This author did not inoculate males. Wolff maintains that in by far the greatest number of cases of so-called congenital tuberculosis the disease has been acquired by infection after birth.

Baumgarten; who has always been the strongest advocate of hereditary tuberculosis, collected all the observations which could substantiate his view. He appeals in the first place to the tuberculosis of birds, as of chickens, though the disease is here caused by a special species. In these animals, in the absence of sputum or of feces containing bacilli, dissemination by the outside world is scarcely possible. He appeals to the fact also that in man cases of congenital tuberculosis are no longer so very rare. To be exact here, too, in the whole range of literature ten cases have been collected up to the present time. Baumgarten was himself able to demonstrate a caseous mass in a cervical vertebra in a still-born child. He further cites the cases of tuberculosis in children in the first months and years of life. Here of course a positive demonstration of congenital presence of tubercle bacilli cannot be adduced. The author thinks, however, that no good ground can be cited against this view, as the disease is accustomed to show itself only very slowly. In fact, Baumgarten invented a period of latency to account for the new growth. The predominating frequency of primary lymph-gland, and bone, and joint tuberculosis speaks again for congenital transmission. Further support is furnished by experimental investigation. Baumgarten got from two tuberculous rabbits, two young which were isolated and protected against infection immediately after birth. They lived three-fourths of a year. In one there was no disease, in the other a caseous nodule of the size of a cherry developed in the liver with the histology of a solitary tubercle, in which, however, bacilli were not found—rather dubious proof.

Better results were obtained by de Renzi and Gärtner. De Renzi selected for his experiments guinea-pigs, which have a longer pregnancy than rabbits. Of eighteen experiments, five furnished a positive result. In the case of three new-born killed at once, this author saw tuberculosis of the lungs, of the bronchial or tracheal lymph glands. Four animals born at the same time lived two months, two lived thirteen days longer. They all showed extensive tuberculosis of the lymph glands. The importance of the longer pregnancy is shown by the fact that only such mothers cast tuberculous young which had been infected thirty days before, longer thus than the whole period of pregnancy of rabbits.

Gärtner rubbed up the newly born young of tuberculous white mice, and injected the mush into the peritoneal sac of guinea-pigs. He got from ninety-six young, out of nineteen casts, three cases of pronounced abdominal tuberculosis. Further, he injected into the blood of ten pregnant rabbits culture solutions, and three of the fetuses extracted from the uterus showed bacilli.

White mice and canary birds were further used. These animals, while they are susceptible to the disease, do not succumb for at least three months after the injection of considerable numbers of tubercle bacilli. Of 110 young mice, the offspring of 24 tuberculous (inoculated) mothers, two were found to be tuberculous. Of nine eggs from two tuberculous canary-birds, two contained tubercle bacilli. Mafucci had already shown that infected hen's eggs need not perish but may continue to develop, while the issuing fowl may show signs of general infection without local lesion. The *possibility* of fetal infection is, therefore, established.

And infection of the human fetus by the mother has been proven also. It was in the year 1891 that Schmorl and Birch-Hirschfeld published the first case in which they were able to demonstrate with certainty the transmission of the tubercle bacillus from the mother to the fetus. It was the case of a young woman who died with miliary tuberculosis in the seventh month of pregnancy. These observers found in the placenta in the inter-villous tissue, also on and between the epithelium of the villi, in the lumen of divided chorion vessels, in the lumen of capillary vessels, in the fetal liver, tubercle bacilli which could be colored with characteristic reaction. Moreover, three guinea-pigs which had been inoculated with parts of fetal organs became tuberculous. As these authors urged, there was in this case clearly a congenital tuberculosis, since all tubercular tissue changes were absent. The direct transmission of tubercle bacilli from the mother to the fetus was thus assured for the first time. Lehmann subsequently confirmed this report with another case.

In reviewing these various observations, Ribbert concludes: We must admit that a large number of interesting studies may be utilized as points of support for the possibility of congenital transmission of bacilli, but that strict proof has been brought only for placental infection to account for congenital human tuberculosis.

Infection in this way is, however, only a possibility, and that it does not thus occur as a rule is proven by the fact that the offspring of tuberculous mothers is born as a rule sound and free. Epstein observed that tuberculous mothers, notwithstanding an emaciation of high degree, bring forth, as a rule, healthy and sound children, which develop in every way normally, and in the exceptional case of feebleness at birth the emaciated children of such mothers recover perfectly when properly fed. Of 200 cases of this kind, tuberculosis was found upon autopsy only once, and then in a child aged ten weeks. The fact is, as Klebs has shown, that an intra-uterine transmission of tuberculosis from an infected mother belongs to the rarest occurrences. Long before the discovery of the bacillus, Bockendahl declared: "We may not conceal the fact that pathological experiment has compelled us to recognize in tuberculosis an infectious disease, and to surrender the view of inheritance even in individual cases." Is it not safe to say that no one here has

ever seen a case of congenital tuberculosis ?

As to transmission from the father, which alone can constitute indisputable heredity, there is no proof at all. Gärtner inoculated twenty-two rabbits in the testicle, and observed that although the semen contained bacilli, it failed in all cases to produce tuberculous young. The reason was obvious with the observation that in these inoculations only one bacillus would be present to fourteen million spermatozoids, so that the chances for infection in this way are reduced to a minimum. It could not further be shown that spermatozoids ever incorporate bacilli. In fact, they could not be forced to take them up. With any increase in the number of bacilli, it was impossible to infect the fetus, and only rarely did there occur a local infection of the female. When it is considered that on the one hand the tubercle bacilli are so rarely found in the semen, and on the other hand primary congenital tuberculosis is itself so rare, it may be concluded that tuberculosis is never conveyed to the fetus by the spermatozoid. Thus practically tuberculosis is not an inherited disease. It is universally admitted that tuberculosis is extremely rare in the first months of life. Thus it is almost never seen in foundling-houses. In the foundling-house at Prague, Epstein saw in 200 post-mortems, only nine cases of tuberculosis. Two of these children had been brought into the institution from an outside nursery, where one of the nurses had been affected with the disease. The history of the other was unfortunately not examined in this direction. But in the case of the other seven of the sucklings, the mothers had been brought to the hospital to be themselves treated for phthisis. In the St. Petersburg foundling institute, according to Froebelius, of 71,370 foundlings, deaths from tuberculosis were 0.4 per cent., while the whole number of deaths was 21.7 per cent.

As now direct germinative transmission of the bacillus cannot be proven in man, and placental infection is extraordinarily rare, retreat is had to the transmission of a tendency whereby it is said that the children of tuberculous parents inherit a weaker constitution, or some other peculiarity which constitutes a predisposition to tuberculosis, which in turn makes these children therefore more ready victims to the disease. Why may not be inherited weak lungs as well as weak brains, weak stomachs, weak eyes, etc ?

Mention has been made already of the paralytic thorax, the elongated, flattened thorax, which is usually found in connection with a long, narrow neck, a thin skin with apparent blue veins, an enfeebled musculature, etc. This condition is declared to constitute the phthisical habitus. The truth is, these individuals are often already the hosts of the tubercle bacillus, and are not infrequently the victims of manifest disease. Deutsch has shown by abundant measurements and comparisons that there is no predisposition in the configuration of the thorax, and that broad-chested men contract the disease as readily as those with narrow chests.

It is claimed that certain catarrhal conditions of the mucous membrane predispose to the disease. This may be, but the fact has not been demonstrated. Brehmer says that a chief source of phthisis is its tendency to catarrh, and prevention of the disease consists in exercise in the open air with protection of the skin with woolen, but not too warm, clothing, etc. The truth is often here, too, the reverse of this relation. It is the individual infected with phthisis who is especially disposed to catarrh. As a sign of incipient phthisis Cullen said a century ago : "The patient takes cold with every exposure, and often without any exposure at all."

Conditions which markedly interfere with the nutrition of the lungs are declared to favor the retention and growth of microörganisms. Thus it has been noticed that individuals in whom the pulmonary artery is small, easily become victims to this disease. Congenital stenosis of the pulmonary artery is nearly always attended with, or followed by, tuberculosis. On the other hand, certain anatomical conditions render an in-

dividual less liable to be attacked. Such conditions as favor venous stasis or hyperemia offer obstacles to the development of tuberculosis. Thus tuberculosis does not occur, as a rule, in cases of valvular disease of the heart, asthma or emphysema. Beer claims to have cured a number of cases of tuberculous bone and joint disease by a passive hyperemia of artificial induction. Exceptional cases sometimes admit of explanation. Thus clinicians differ as to the effect of aneurism of the aorta. Aneurism of the aorta, so long as it causes a venous stasis, interferes with the development of tuberculosis. When it, however, attains such size or disposition as to encroach upon the pulmonary artery, it will favor tuberculosis. Schottelius finds a difference in the configuration of the bronchial tree. Formad accuses the construction of the connective tissues. Veraguth holds responsible the lymph vessels. Ruehle generalizes in a lighter vulnerability, etc. Defective ciliary action has been invoked in the same way. Appeal is made to hypoplasia of the heart, and to chlorosis, both of which are common effects of the disease. Finally, Brehmer, in what might be called a frantic appeal for predisposition, lays the blame upon anorexia, for he says a common peculiarity of almost all cases is that the patients are never good eaters. This author actually puts this statement in italics. "*Patient war nie ein starker Esser!*"

[CONCLUDED IN NEXT NUMBER.]

Bichromate of Potassium in Gastric Affections.—The use of bichromate of potash was recommended by Vulpian in 1883 in stomach troubles.—Before his time it had been employed as an emetic, and in syphilitic, bronchopulmonary and nervous disorders, and later Drysdale advocated its use in affections of nearly all the important organs of the body.

In 1884 Dr. Thomas B. Fraser treated a number of cases of dyspepsia and gastric ulcer by this drug, and his results were so favorable that he brought them before the medical congress at Rome and recorded them in the *Lancet*. The dose of the bichromate of potash in these cases varied from one-twelfth to one-sixth grain three times daily.—The drug should be given during fasting and on as empty a condition of the stomach as possible. It was given in pill or solution and there was usually no difficulty in getting the patient to take it.

Dr. Fraser found that it relieved most of the symptoms of dyspepsia in a short time, except the constipation and anemia, and it especially removed pain, nausea, vomiting and gastric tenderness. It seemed to help little the anemia of these cases and its therapeutic benefit was the result of an action restricted to the stomach. In a few cases of acute gastric ulceration with hematemesis the results were not good and he thought its astringent action was very slight, yet it possesses a strong anti-putrefactive power. This probably constitutes one of the causes of its anti-dyspeptic therapeutical value, but there are other causes not yet discovered.

Phenacetine in Intermittent Fever.—Dr. Bernheim) *Il. Raccoglitore Medico*, No. 12, 1893) claims that phenacetine is capable, like the sulphate of quinine, of suppressing the attacks of intermittent fever, if only it be administered in the proper doses and at the right time. Its action is manifest after an hour, reaching its maximum in two hours and ceasing in five to six hours. Hence it follows that it is best given from two to three hours before the onset of the attack. A dose of one gram (fifteen grains) is preferably given at first, and in obstinate cases, one-half to one gram (seven-and-a-half to fifteen grains) two hours before. No inconvenient or disagreeable results were observed.

THE EYE AFFECTIONS OF DIABETES.

Read at the Ninety-Sixth Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 24-27, 1894.

By Harry Friedenwald, A. B., M. D.,
Lecturer on Ophthalmology and Otology at the College of Physicians and Surgeons, Baltimore.

A large number of those suffering with diabetes mellitus present eye affections. Vision may become impaired in various ways. The seat of the disturbance may be in different parts of the eyeball, in its muscular apparatus, in the optic nerves, or even in the brain. There may be degenerative hemorrhagic or inflammatory lesions which interfere with the transmission of light by the refractive media or with its perception by the nervous elements. On the other hand, the disturbance may be of the kind called functional, due to lesions in part still undiscovered. It is not the purpose of the writer to consider all the diseases of the eye, which have been found associated with diabetes—it would occupy too much time and many of these conditions are very rare. A survey of the more important will be made very briefly and a few illustrative cases will be related.

The normal eye is able to secure distinct images of objects situated at different distances by its power of accommodation. This power depends upon the action of the ciliary muscles ; it gradually diminishes as we grow older, and after the age of forty, a normal eye is no longer able to see objects clearly which are close by, and finds it necessary to aid the weakened accommodation with gradually increasing convex glasses. Their strength bears a definite relation to the age of the patient. However, it is not only years that bring weakness of the power of accommodation ; various exhaustive diseases causing general muscular debility also affect the muscle of accommodation, and it is therefore evident why diabetes frequently forces patients to use reading glasses earlier than we would expect, or to use stronger glasses than their years justify. I have known of cases in which diabetes was discovered through this apparently unimportant symptom.

Less frequent, but still more characteristic, is complete *paralysis of the muscle of accommodation*. Let me illustrate this by a case : W. S. H., aged forty-five, a laborer, was admitted October 10, 1893, into the City Hospital in the service of Professor Latimer. He had noticed the symptoms of diabetes since February, and his weight became reduced from 180 to 112 pounds within that time. When admitted he passed about 30 pints of urine daily, of a specific gravity of 1034. His diet was regulated and he was given codeine. October 14, the daily amount of urine was reduced to ten pints. On the following day he complained that his vision had rapidly diminished, that he was unable to see at a distance or to read. The ophthalmoscopic image, the field of vision, the size and reaction of the pupils were normal. He had previously been wearing 1-16 inch glasses for reading ; on placing these before his eyes, his distant vision, which had been 1-5, became normal. It required very strong glasses to enable him to read, and it was evident that there was complete loss of the power of accommodation and that his entire hypermetropia had become manifest. The paralysis of the accommodation remained complete until November 10, when it began to improve rapidly. November 15, he was able to see as well at a distance as before the attack and to read with his old glasses. At this time he was passing about eight pints of urine daily. At the time this patient had paralysis of the accommodation he was in about the same general condition as just before and after. He was about the hospital, could climb stairs ; his

general debility was not such as would explain the entire loss of accommodation. We must therefore look for another explanation. The affection described bears great similarity to the more common post-diphtheritic paralysis of the accommodation, and we are inclined to believe that both depend upon peripheral neuritis, due to the poisonous action of some abnormal constituent of the blood. Paresis and paralysis of the different extrinsic ocular muscles occasionally depend upon diabetes. They are due to peripheral neuritis and peripheral nerve hemorrhages, or more rarely to nuclear trouble. These affections produce annoying diplopia, but show nothing characteristic. The muscles most frequently affected are the external recti (Hirschberg). These paralyses are usually transitory, and frequently improve when the primary disease is treated and relieved. Those paralyses coming on in the later stages of diabetes, and due to nuclear trouble, offer a bad prognosis. In connection with peripheral neuritis of the ocular nerves, let me call to mind the not infrequent peripheral neuritis of diabetes, manifesting itself as neuralgia or diabetic tabes.

The most common complication of diabetes is *cataract.* This is well known, and we shall dwell on it but a moment. A diabetic cataract may come on at a very early age, and has a tendency to mature rapidly. In this connection let me relate the case of J. S., a patient at the City Hospital. He was a colored boy aged fourteen years, and came to the hospital early in 1893, to be treated for malarial fever and bronchitis. When he entered, the presence of sugar in his urine was detected, at times, though not constantly. I considered the diagnosis of diabetes established by the fact that there were well developed radiating opacities in both lenses (cortical) without any other pathological conditions.

The formation of diabetic cataract often begins with, or is even preceded by, swelling of the lens. This may produce myopia. When myopia makes its appearance in an adult, it should arouse our suspicion.

In those under fifty, the association of the spontaneous formation of cataract with diabetes points to an intimate causal relation. In the aged, less stress can be laid upon the discovery of small quantities of sugar. Berger suggests that we may consider diabetes as not being the cause of cataract in those old persons whose health is otherwise unimpaired. The explanation of diabetic cataract is still much disputed. It appears to be the result of a disturbance of nutrition of the lens and of degeneration of certain elements from the action of irritating substances. It is in the graver forms of diabetes in which large quantities of sugar are excreted that we most frequently find cataract.

There is still a point of practical importance which should be mentioned, namely: that the prognosis of the cataract extraction is not quite as good as in uncomplicated cases. This is partly due to the great impairment of the general nutrition of the patient and partly to the liability to iritis after any operative interference. This may be illustrated by a case of very marked diabetes in a lady aged about 65, who had excreted large quantities of sugar for a number of years, and who had double diabetic cataract. My father and I operated on one eye, and both the preparatory iridectomy and the subsequent extraction were followed by a severe iritis. This patient had had double iritis several years before the operation, probably diabetic in its nature. Let this reference suffice to call to mind the fact that diabetes is a factor in the production of iritis. In our patient the repeated attacks of inflammation of the iris caused the formation of such an amount of connective tissue blocking up the entire pupillary space, that vision was subsequently almost as bad as before the operation.

The most characteristic eye-complications of diabetes are various forms of *retinitis.* The more important forms of this affection are as follows: 1st. A form of hemorrhagic retinitis in which hemorrhages of various sizes are found scattered in the retina, frequently so large as to break through into the vitreous; besides these, various degenerative and inflammatory lesions may be found.

This form is not as characteristic as is, 2d. The retinitis in which we find small, white, shining spots in the central part of the retina, lying in the retinal tissue. They are most marked in the macular region, may become confluent and form long streaks, but they rarely present the stellate form of albuminuric retinitis. Small hemorrhages may be scattered among the white spots. This form, first described by Hirschberg, is considered by him as pathognomonic of diabetes. The distinguishing feature, according to this author, and the one which differentiates it from albuminuric retinitis, is that the papilla and the blood vessels appear perfectly normal in diabetic retinitis, while in the albuminuric form they always present characteristic changes. This form of retinitis usually comes on in persons between 45 and 65 years of age, who have had diabetes for a number of years. Like other diabetic affections it is always bilateral. Vision may be greatly impaired, but this affection does not lead to complete blindness. I described a characteristic case of this form several years ago; another has recently come under my observation. Mrs. B. aged 60, had been treated for cutaneous gangrene of the lower part of the leg, the disease having been considered as senile. As far as I could learn no suspicion of diabetes had been entertained. I was asked to prescribe glasses for her somewhat impaired sight (V., R. E., 4-18; V., L. E., 4-36) and found slight beginning cortical cataract in both eyes, but beside this, what was more important, the characteristic form of diabetic retinitis, just described. The area between macula and papilla was studded with smaller and larger brilliant white spots, arranged in an irregular manner, and often forming conglomerate masses. I examined the urine and found both sugar and albumen. Still I have no hesitation in considering this simple diabetic retinitis, for it presented all the characteristics, and there was not the slightest involvement of the papilla. It is important to bear in mind that this affection appears only at a late stage of diabetes, and that it is not infrequently found in cases in which albumen is excreted in small amounts at the same time or later.

The last affection to which I wish to direct attention is diabetic amblyopia. This may appear with or without any ophthalmoscopic alteration of the papilla. The visual disturbance is usually very similar to the partial blindness due to excessive smoking and drinking—the central portion of the field of vision, *i. e.*, the part at which the gaze is directed, is obscured. A number of such cases have been attributed to diabetes, which were in reality due to tobacco and alcohol, but it is equally certain that cases of this form of amblyopia which occur in diabetic persons are not always to be ascribed to excessive smoking and drinking, even though the statement to this effect has been made by an eminent authority. The following case will serve as an example: A lady aged 55 had had almost perfect vision in 1890, when I first examined her (with + 2,25 Ds, V., = 1). There was slight weakness of the accommodation (+ 4½ Ds, were used for reading). Diabetes was discovered in this patient in the fall of 1893. The specific gravity became as high as 1030, the amount of urine rose to 80 oz. daily and there was 4 per cent. of sugar. These conditions could be readily improved by regulating the diet. In September, 1893, the patient complained that her sight was failing her, and the examination showed that it was reduced about ½ in each eye. There were no visible pathological changes in the eyeball, and the limits of the field of vision were normal, but on examining at and about the point of fixation with small colored spots, the characteristic blurring of the centre of field vision became apparent. In this case there were no doubts left as to the cause. We had before us a case of simple diabetic amblyopia. These cases may improve, may completely recover—but they may also remain stationary or gradually get worse. Their importance is still greater as an index to general prognosis. Hirschberg has shown that these cases frequently terminate within a short time in diabetic coma.

The cause of this affection seems like-

wise to be due to a toxic substance which produces a retrobulbar optic neuritis, in the same manner as in alcoholic or tobacco poisoning. Those forms referred to above of visual impairment, with evident changes in the papilla, may lead to atrophy and complete blindness. These are probably often due to hemorrhages in the optic nerve.

Before concluding, let me state that diabetes may last for a long time, and be very grave without giving rise to any eye symptoms. I have examined a number of diabetic patients, without being able to detect any ocular changes. In a patient about 60 years of age suffering with diabetic marasmus and gangrene, I was unable to discover any abnormality in the eyes shortly before death.

There is one lesson which the facts that I have brought before you have impressed upon me in a very strong manner: In the study and treatment of many of the eye affections referred to above and of others, the oculist must not omit the examination of the urine for sugar, and the general practitioner should not disdain to look to eye-symptoms as aids in the diagnosis and in the broader study of diabetes.

922 Madison Avenue.

SOCIETY REPORTS.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING MARCH 2, 1894.

The 292nd regular meeting was called to order by the President, Dr. J. E. Michael.

Dr. G. J. Preston read a paper advocating the establishment of Detention Wards for Cases of Suspected Insanity.

Dr. Billingslea spoke of a case which had recently come under his notice where a lady of respectable family became suddenly deranged and was arrested while in a city store and confined for two days, first in the station-house and then in the city jail, before being sent to an asylum. He thought that detention wards were needed for such cases.

Dr. John Morris thought that there was a great necessity in Baltimore for a detention hospital or ward. He did not think that the station house or jail or general hospital was a fit place for cases of suspected insanity.

Dr. G. H. Rohé agreed with Dr. Preston as to the necessity of detention wards and spoke of a class of cases not mentioned by Dr. Preston, namely, persons pronounced insane by examining physicians, but who at present must be kept at home until arrangements can be made to transfer them to some institution, often with great inconvenience, and even danger, to the relatives.

Dr. Preston hoped that some hospital would inaugurate such wards and believed that the city and State would aid in the construction and maintenance of the ward.

Dr. R. B. Norment read a paper on The Management of Typhoid Fever in Private Practice Among the Poor and Middle Classes. (See Vol. XXX, page 507.)

Dr. Osler said he would like to be under Dr. Norment's treatment if he had an uncomplicated case of typhoid fever without pyrexia. He thought the antipyretic drugs were entirely superfluous in this disease. The cold bath is more efficacious but is not always available in private practice; but all the good effects of the bath can be obtained by sponging. A good nurse or doctor can sponge the patient so effectually that the fever will be satisfactorily reduced. When the temperature is high, ice-sponging—not with ice-water, but with lumps of ice—over the back and legs will reduce the temperature very pleasantly to the patient and satisfactorily to the doctor. Delirium and stupor are also effectually treated by ice sponging. The use of the modern antipyretics in typhoid fever is in nine cases out of ten positively hurtful; they reduce the heart's action and cause weakening sweats and their use is an unmitigated evil. In the great majority of cases, the treatment may be taken from old Dr. Nathan Smith, of Yale, which was pretty much that of to-

day : Plenty of fresh air, liquid diet, and cold externally. He was in the habit of turning out the friends of the patient, putting the patient on the floor and then dashing water, handed through the window by an assistant, over the patient.

Dr. Winslow did not believe that it was necessary to give medicine in typhoid fever, except in special cases. Before using the cold-bath system he had used antifebrine and was pleased with the results. It gave the patient comfort and no bad results were observed.

Dr. G. J. Preston, speaking of the coma of typhoid fever said that while cold baths were best for this condition, yet in some instances it did not relieve it. Strychnine and caffeine used hypodermically have given good results. Recently he had seen very good and prompt antipyretic effects from the use of 20 to 30 drops of guaiacol applied externally.

Dr. Pearce Kintzing said that he could not overcome the prejudice of people against cold water. He uses antifebrine with quinine. With this he secures a reduction of temperature for five or six hours. After cold sponging the temperature comes up quicker.

Dr. J. M. Craighill had never had and trouble in getting his patients sponged with cold water when a little vinegar was added to the water. In the better class of patients he had alcohol added to the water.

Dr. C. W. Mitchell had had considerable experience with typhoid ; he has used antipyretic drugs, and his results are as good as those reported by those who have not used them. The majority of cases which he loses are not those having high temperature. Phenacetine is by far the best antipyretic in his experience. He uses it in small doses, 2½ grains every four hours. He gives tonic doses of quinine in the early part of the day and 2½ grain doses of phenacetine until midnight. It is impracticable in private practice among the poorer classes to use the bath. One of his patients, a child, was made worse by the fright which occurred every time the bath was used. Deaths are not due to high temperature and occur in those cases where a bath would not have saved them.

Dr. Norment believed that in this part of the country amongst the poorer classes, the prejudice against the use of the bath in disease was insurmountable. Under these circumstances, some of the antipyretic drugs occasionally do good.

Dr. Osler, replying to a question of Dr. Norment, said that he did not believe in the use of alcohol as a routine practice, but in such cases as Dr. Norment had referred to, where there was pronounced weakness and in hypostatic congestion, the use of whiskey was very valuable. He preferred it in combination with strychnia.

Dr. John Morris then introduced the following resolution :

Resolved, That in furtherance of public order, public decency and humane sentiment execution by electricity should be substituted for hanging as the death penalty for crime.

Dr. J. E. Michael was opposed to the resolution. He did not believe that death by electricity was any more rapid or less painful than by hanging. He was heartily in favor of capital punishment and thought hanging preferable to any other mode of execution, for it was not complicated and not bloody.

Dr. Norment was not opposed to capital punishment, but he was opposed to electrocution. He thought that death by chloroform was advisable, being painless and cheap.

Dr. G. J. Preston was opposed to capital punishment, but as long as capital punishment existed he was in favor of hanging and opposed to electrocution. He had seen one person hung, and he thought that electrocution could not equal it for humanity.

After further discussion the resolution was lost by an almost unanimous vote.

STATED MEETING, APRIL 6, 1894.

The 294th regular meeting of the Clinical Society of Maryland was called to order by the Vice-President, Dr. Herbert Harlan.

Dr. G. L. Taneyhill read a paper entitled NOTES ON AND PERSONAL EXPERIENCE WITH PUERPERAL MANIA. (See page 3.)

Dr. Julius Friedenwald then read a paper on the EXTERNAL USE OF GUAIACOL AS AN ANTIPYRETIC, comprising work done in conjunction with Dr. H. H. Hayden.

This drug was applied in seventeen cases, eight cases of pneumonia, two cases of typhoid fever, two cases of pulmonary tuberculosis, one case of malaria, two cases of influenza, one case of acute articular rheumatism, one case of facial erysipelas.

Their conclusions are:

1st. That this drug has a powerful antipyretic action, occasioning a reduction of from one to four degrees of temperature in from one to four hours.

2d. That in all cases this reduction of temperature is accompanied by profuse diaphoresis; which may or may not be accompanied by a chill or chilly sensation.

3d. That great exhaustion is frequently produced.

4th. That the effects may be obtained from comparatively small doses (from 30 to 50 drops) and that great care should therefore be exercised in the use of the drug. The drug should be applied but once or twice daily and the initial dose should not be above 30 drops.

5th. That the effect produced by guaiacol, though more powerful, is the same as is obtained from most of the other antipyretics of the coal-tar series and that the same care must therefore be exercised as with the other preparations. Its effect differs from the stimulating cold bath in being *depressant.*

6th. That the main indication for its use is in diseases accompanied by high fever in which the cold bath cannot be applied. It may therefore be especially useful in typhoid fever as well as in all other diseases accompanied by high fever in which irritability of the stomach prevents the use of other antipyretics.

Dr. Kintzing: It seems that Dr. Friedenwald did not vary the dose. Perhaps he might have received the same fall in temperature in some of his cases on smaller dose and had less depression.

Dr. Fleming: I have tried the drug in two cases and had such depression in both that I decided not to use it further.

Dr. Norment: I see two troubles in regard to use of guaiacol. First, the depression is very sudden, and second, the reaction is violent. It seems to me from Dr. Friedenwald's paper that guaiacol is of very questionable value in private practice.

H. O. REIK, M. D.,
Secretary.

MEDICAL PROGRESS.

LACTATE OF STRONTIUM IN NEPHRITIS.—In an exceedingly instructive clinical lecture by Dr. J. M. DaCosta in the *Medical News*, three cases are related, illustrating different stages and forms of nephritis, and showing, in his opinion, the value of the lactate of strontium in this malady. Stevens' Manual of Therapeutics, published by Saunders, describes the lactate of strontium as a white, granular powder, odorless, and of a slightly bitter saline taste; soluble in water and alcohol. Dose, ten to thirty grains.

DaCosta gave it in thirty-grain doses in solution four times a day so that the patient received from a drachm-and-a-half to two drachms daily. In his cases the results were striking, the urine was increased in quantity, the bad symptoms disappeared and in one case recovery seemed to be complete.

In conclusion, he says:—I must confess, in the main, that what I have shown you to-day of the effects of the lactate of strontium in cases of nephritis only confirms my previous observations with this agent. The salts of strontium are valuable as diuretics in renal affections, and they are particularly valuable in the acute forms, but do less good in the chronic forms. They do not, according to my experience, act so much upon the structure or tissues of the kidneys as they do upon its secreting function. They are admirable diuretics. The claim that has been made by some French clinicians that strontium salts markedly reduce the amount of albumen in the urine has not been fully confirmed in my experience, except that the rela-

tive proportion of albumen is greatly reduced by the great increase in the quantity of the urine secreted. There is, however, some slight diminution in the amount of albumen, as well as increase in the quantity of the urine, especially in the acute forms. Whether in the parenchymatous and interstitial renal diseases these salts act beneficially upon the diseased or degenerated structures, or simply act as diuretics, has not been finally settled; but they certainly accomplish more good in the acute than in the chronic forms of nephritis.

* * *

To Beginners in Laparotomy.—Dr. F. Byron Robinson, in the *Medical Age*, offers the following practical suggestions to laparotomists:

1. Remember it is criminal to learn to do laparotomy on a patient.

2. Do not attempt to do laparotomies in private houses and with no nurses.

3. Before doing any laparotomy be sure to study under a master, and assist him if possible, so you can see the pathology in the abdomen and how he removes it. Ask him to allow you to tie a knot once in a while. Never lose the chance of assisting in or witnessing a laparotomy.

4. Learn the after-treatment. Half the battle is with the intestines.

5. Study carefully the abdominal and pelvic viscera of the cadaver. Study as many cadavers as you can. Never lose the chance of doing a post-mortem or attending one. Study the dog's viscera.

6. Be sure to make systematic experiments on dogs' abdominal viscera. Always do the autopsy on your dogs yourself. Note what damage to the peritoneum your manipulations did. Observe what peritonitis really is.

7. Be clean without chemicals. Learn to use very few instruments. Beginners should always invite a laparotomist friend to be present.

8. Be careful of promises.

* * *

Pancreatic Colic.—Minnich relates in the *British Medical Journal* a case in which a certain diagnosis was possible. When 40 years of age a man, now aged 68, had severe attacks of gall stones, the stones being found in the stools. He then had the best of health for ten years and a half, when the attacks recurred. One year ago he was seized with severe pain in the epigastrium, which he attributed to gall stones, and a further attack occurred eleven months later. He was a well-nourished man, and complained of pain, which became localized in a definite place under the left costal arch within the nipple line. The sclerotics were slightly yellow, but the urine and skin were unchanged. The attacks were repeated from time to time. Concretions of irregularly rounded shape were found later in the stools. They could be crushed with the fingers, and presented a smooth surface of a slightly yellowish grey color. The cut surface was dull white and not laminated; the diagnosis was obvious. Any complication such as carcinoma or abscess appeared to be quite excluded. Complete obstruction to the outflow of the pancreatic secretion must, in contrast to biliary obstruction, be rare owing to anatomical conditions. The cessation of the secretion may be due to atrophy of the gland. The evacuation of characteristic calculi, the presence of pancreatic colic and even jaundice (owing to the passage through or delay of the stone in the intestinal portion of the duct) are among early symptoms. One symptom will not suffice for the diagnosis.

* * *

Surgery of the Chest.—Delagénière, in a paper on the surgery of the pleura and the inferior lobes of the lungs (*British Medical Journal*), advocates extensive resection of the ribs in cases of chronic empyema and of pulmonary affections—abscess, gangrene, hydatid cyst—causing purulent effusion into the pleural cavity. It is held that the persistence of a fistula after ordinary operations for fistula is usually due to collection of pus in a cavity, called the costo-diaphragmatic *cul-de-sac*, between the sixth and two following ribs on the one side and the vault of the diaphragm on the other. With the object of obliterating this space the author has practiced with success almost complete removal of these three ribs. This prac-

tice is associated with free drainage of the cavity at its most dependent parts. After removal of the ribs and removal of all secretion the sides of the sac fall together and form adhesions, so that the cavity is completely obliterated. The author acknowledges that if the lung be so bound down by thickened membrane that it cannot expand, any operation on the chest wall would be quite useless, but he argues that this result is not so frequent as is generally supposed, and also that on free exposure of the confined lung much of the thickened membrane may be removed. Several interesting cases are related, and the treatment of localized gangrene and of hydatid cysts and tumors of the lung is discussed at full length.

* * *

The Removal of Postnasal Adenoid Growths.—The serious and far-reaching influence which adenoid vegetations in the postnasal space, if not removed, may have on the bodily health and mental development of growing children is now generally recognized.—Not many years ago such operations were in the hands of one or two specialists whose procedures were looked upon by the profession at large as something in the nature of esoteric mysteries; now the postnasal space is no longer a surgical *hortus inclusus*. Although the operation has become almost a matter of every-day surgery, there is still considerable diversity of opinion among operators, not merely as to the details, but to some extent as to the principles of procedure. The discussion at the Laryngological Society of London last week, as reported in the *Lancet*, was, therefore, as opportune as it was important. With regard to the specific point in debate, namely, the choice of an anesthetic, this appeared to be, as in other operations, largely a matter of individual preference. There was, however, practical unanimity as to the necessity of the anesthetic, whatever it might be, being administered by a specially skilled expert. As to the degree to which anesthesia must be induced, we agree with the President, Dr. Felix Semon, that it should never be pushed to the abolition of the laryngeal reflex, so that the patient may retain the power of coughing up any blood that may find its way into the larynx. That the removal of postnasal growths is not free from danger is sufficiently proved by the fact that a certain number of deaths have been recorded, and several others are known to have occurred which have not been published; in most of these cases it is probable that the immediate cause of death was the entrance of blood into the lungs. Another conclusion to be drawn from the discussion is that in the removal of adenoid growths the operator must, like Strafford, take "Thorough" as his guiding principle. He must remove the growths completely, and he should allow himself sufficient time to do so; attempt at display or "record-breaking" is here altogether out of place. Rapidity in operating too often means recurrence of the disease, and consequent disappointment to the patient's friends and discredit to the surgeon.

* * *

A Convenient Antiseptic Under-Sheet in Child-Birth.—Ordinary tarred paper, such as is used in building, makes a very efficient protection in child-birth, etc., as an antiseptic and waterproof under-sheet. It is to be slipped under the ordinary sheet and when its usefulness is over may be rolled up and burned, the tar aiding the combustion. It is cheap and always obtainable. Rolled into a cornucopia, of greater or lesser size, and secured by eyelets, staples or stitching, it is a convenient receptacle for dressings and refuse in surgical or medical cases. A small one filled with absorbent cotton or plaster or antiseptic sawdust may serve with advantage as a spit-cup in various diseases. These, like the sheet, can be easily burned.

* * *

Gallobromol in Gonorrhea.—A new remedy suggested for the treatment of gonorrhea is gallobromol. Cases with much discharge are said to recover in a few days after frequent and abundant irrigations of one to two per cent. of this drug in water. At least a pint of the solution should be used at each irrigation.

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See Publishers' Department, Page 58.

BALTIMORE, MAY 5, 1894.

EDITORIAL.

The Treatment of Seasickness.

EVERY now and then remedies are extolled as being specifics for that distressing malady, seasickness, and yet sufferers from this trouble often pin their faith in vain to a new treatment and endure on to the end of the voyage. The only true and rational preventive of seasickness is to stay on land, but for those who will or must go to sea, Dr. M. Charteris, of Glasgow, recommends, in the *Lancet*, a compound called chlorobrom, as a specific. The reports which are gathered from those who go down to the sea in ships, such as captains and others are, to say the least, very rose-colored and in every way seem to be favorable. The drug may be taken before starting or if this has not been thought of, treatment may be begun on board ship, and the effects seem to be equally good. In long voyages seasickness has time to wear off in most persons, but in short trips where the evil continues all through the water voyage and still on land, the value of a specific is more particularly appreciated. Dr. Charteris summarizes his conclusions on this treatment as follows:

1. In *long* sea voyages no prophylactic benefit can be secured by the use of chlorobrom unless for two nights before embarkation the passenger pays due attention to the stomach and bowels by taking a cholagogue pill. Further, in the case of a person who dreads a voyage a dose of the solution should be taken. 2. The diet on board ship should be "spare and dry." Soup, pastry, and sweets should be especially avoided, and no full meal should be indulged in. A hypnotic dose (one tablespoonful and a half for a male, and one tablespoonful for a female) should be taken for three nights. 3. In *short* voyages, when the steamer leaves, perhaps, at 10 P. M., the passenger should immediately retire to rest, and take one of the doses mentioned. 4. In a *shorter* passage across the Channel a teaspoonful should be taken before going on board. 5. By following these directions immunity from sea-sickness is obtained in the great majority of cases, but if they be not followed it is to be remembered that chlorobrom has no effect in arresting an outburst of vomiting. If it is given in a teaspoonful dose every ten minutes until a tablespoonful and a half or a tablespoonful have been taken, it will almost invariably check retching and depression.

* * *

Medical and Chirurgical Faculty.

THE annual meeting of the Medical and Chirurgical Faculty last week was in all respects a very satisfactory one. Formerly when section work was followed the number of volunteer papers was small and they were often considered unimportant. Now, however, since the abolition of this antiquated work by sections, the number of volunteer papers is large enough and varied enough in character to satisfy all members. Of particular interest was the innovation, which is greatly to the credit of the programme committee, of devoting one evening to the discussion of a special subject. This year the diagnosis, prognosis and treatment of empyema were taken up and the opinions and experiences from a medical and surgical standpoint formed a decidedly instructive part of the week's proceedings. The general interest taken at present in the prevention and restriction of tuberculosis was partly evidenced

in the fact that both the president and the annual orator independently took this subject as their themes. Not the least attractive part of the programme were the social features. Not only at the informal banquet after the annual oration, but all through the week, the city and county members had opportunities to become acquainted or to renew old friendships. A few members by death and removal were lost to the society, but as usual a large number of new ones were elected. The increase of attendance on the part of the county members is always a source of congratulation for the society, and not only did several of them contribute papers to the programme, but they discussed papers presented. On the whole the meeting, while showing nothing original, was a very memorable one.

* * *

EVERY now and then the question is asked, "To whom does the prescription belong?" The courts have decided more than once that it belongs to the patient and it can be refilled as often as paid for. Indeed many persons demand a copy of a prescription that has done them good and carry it about with them on their travels to have it filled where they wish. Unfortunately this has too often been the cause of leading unsuspecting persons into a dangerous drug habit. In spite of legal rights, physicians prescribing compounds containing such drugs as morphia, cocaine, chloral, alcohol and others of that kind should always label the prescription "non rep.," which the conscientious pharmacist will generally heed. Too often are victims of the drug habit sent to places of safety to drag out a miserable existence because their physicians or druggists were not sufficiently careful or thoughtful.

* * *

THE dangers from such a collection of the idle and unemployed, as have recently gathered at the National Capital with some wild ideas on legislation, are numerous, and not the least is the spreading of disease by the offscourings and unwashed of other cities and States. A comic paper suggests that a barricade of soap around the Capitol would keep all such men away from the building. To this might be added a raid by the physicians to the poor, each physician armed with an ivory vaccine point. It is just from such a motley collection as this that small-pox, typhoid fever and perhaps worse evils are brought into the midst of an otherwise healthy community. If any action be taken against such an evil as now threatens Washington, it should be prompt and all the laws on health should be enforced at this time with especial rigor.

* * *

MANY medical societies are greatly agitated over the subject of the revision of the code of ethics. It is very likely true that a large number of physicians never saw the code of ethics and know still less of what it exactly treats. The learned judge who dismissed the charge of one physician against another with the remark that he could not master the code of ethics, but that if they would both go home and behave like gentlemen, there would be no necessity for a code, had a very level head. Persons who need codes of ethics, books of etiquette and such guides to govern their behavior will always gravitate to their proper position in time.

OBITUARY.

DR. CUSCO, the inventor of the bivalve speculum bearing that name, died recently in Paris at an advanced age.

DR. CHARLES H. WISSLER, in the thirtieth year of his age, died last week at his residence, 1400 East Baltimore Street. Dr. Wissler was a graduate of pharmacy and of the Baltimore Medical College in 1891. He was unmarried.

DR. JOSEPH WORKMAN, for a quarter of a century superintendent of the Toronto Asylum for the Insane, and the first president of the Ontario Medical Council, died on April 15, in Toronto, Ont., aged eighty-nine years. Dr. Workman was a well-known and valued contributor to medical literature. He had made himself especially familiar with the works of Italian alienists.

DR. WM. V. KEATING, of Philadelphia, died recently at the age of seventy-one years. He was graduated from the University of Pennsylvania in 1844, and in 1861 was elected Professor of Obstetrics in Jefferson Medical College, holding the latter position but for a short time. From 1862 to 1865 he was Medical Director of the United States Army Hospital at Philadelphia. He was the American editor of Ramsbotham's *Midwifery* and Churchhill's *Diseases of Women*. He was the father of the late Dr. John M. Keating.

MEDICAL ITEMS.

Many cases of cholera are reported in Lisbon.

*

Several cases of small-pox have been discovered in this city.

*

The Woman's Medical College, of this city, held its commencement last Tuesday afternoon.

*

Dr. Raymond, of the Salpétrière, has been chosen by the Faculté de Médecine as Charcot's successor.

*

By a recent decision of the Sultan of Turkey women are allowed to practice medicine in his dominions.

*

The American Academy of Medicine will this year hold its meeting at Jefferson, N. H., August 29 and 30.

*

Medical Director A. L. Gihon, U. S. Navy, delivered the address at the commencement of the Albany Medical College.

*

The third annual commencement of the University of Maryland Training School for Nurses took place last Wednesday.

*

Dr. William Osler will deliver the address at the opening of the new Wistar Institute of Anatomy on May 22, at Philadelphia.

*

Maine, Rhode Island and Massachusetts, of the New England States, are still without a law regulating the practice of medicine.

*

Dr. Herbert Harlan has resigned his position as Professor of Diseases of the Eye and Ear in the Baltimore University School of Medicine.

*

Dr. J. B. Murphy, of Chicago, has been appointed one of the honorary presidents at the next International Medical Congress at St. Petersburg.

*

The Brooklyn Board of Health made a vaccination raid one day last week and by the aid of policemen and vaccine physicians vaccinated many persons under compulsion.

*

With yellow fever at Rio, cholera in Russia, Turkey and Portugal and small-pox at Chicago and other places in the United States, boards of health should be on the watch.

The twenty-fifth annual report of the New York Physicians' Mutual Aid Association shows that that corporation has been a great success and a veritable charity to the families of physicians.

*

The results of the examination held hy the State Board of Medical Examiners last Thursday will be published in the JOURNAL as soon as the papers have been graded.

*

At a church fair at Brooklyn, a physician is said to have offered his services for nothing and vaccinated all applicants for fifty cents in order to swell the receipts of the charity.

*

There are seventy-one colleges in the Association of American Medical Colleges and now it is proposed to adopt a rule enforcing a four years' course for all who intend to graduate in or after 1899.

*

Dr. W. D. Miller, an American, has been elected Professor Extraordinarius of Dentistry in the Medical Faculty of the University of Berlin. Dr. Miller is known to American tourists as the American dentist at Berlin.

*

The American Dermatological Association will hold its eighteenth annual meeting at the Arlington Hotel, Washington, D. C., May 29 to June 1. Dr. Robert B. Morison, of this city, will deliver the president's address on the first day.

*

In the report of the Harper Hospital of Detroit, of which Dr. E. L. Shurley is chief of the medical staff and also in connection with Dr. Gibbes, the originator of the Shurley-Gibbes treatment of consumption, 72 cases of consumption were treated with no recoveries.

*

Dr. William Pepper will address the Cleveland Medical Society on June 22, and will give a clinic at one of the hospitals of that city the next day. Dr. Howard Kelly, of this city, was present and addressed the quarterly meeting on March 9.

*

At the International Congress at Rome more than seven hundred physicians of India presented a petition demanding that Latin be the scientific language of medicine, that all modern medical works of value be translated into Latin, that a medical journal be called the *Salernum* after Salerno, where the first medical school was established, and that a

society known as the "Ancient Order of Æsculapians," be organized.

*

Most countries, States and cities give marriage certificates, which are short and simply certify that the marriage has taken place, but in Belgium the certificate of marriage is in form of a little book which contains, in addition, much information, such as an abstract of the marriage laws of that country and hints as to the feeding and care of infants, and at the end a very liberal space is left for the inscription of the names of twelve children.

BOOK REVIEWS.

TABLES AND NOTES ON HUMAN OSTEOLOGY, for the use of Students of Medicine. By Sebastian J. Wimmer, M. A., M. D., with a Preface by Prof. William F. Waugh, A. M., M. D. Philadelphia: The Medical Publishing Co., 1894. Price, $1.50.

A compend is at its best a very dry study, but when it comes to a compend of anatomy of the dry bones it is worse than ever. This little manual, for which a large price is charged, is intended by the author to supplement work and reading of larger books, and it is founded on such works as Gray. It seems to be very correct, and may serve as a convenient aid in preparing for examination.

THE YEAR-BOOK OF TREATMENT FOR 1894. A Comprehensive and Critical Review for Practitioners of Medicine and Surgery. In a series of twenty-four chapters, by eminent specialists. In one 12mo. volume of 497 pages. Cloth, $1.50. Philadelphia: Lea Brothers & Co., 1894.

In the tenth edition of this work, former editions of which have been noticed in these columns, two new articles have been added. One is on the medical diseases of children and the other is on bacteriology. Hygiene also receives a larger amount of attention. At the end is a list of books, authors quoted and also a list of new books published. This is greatly in advance of the ninth edition.

A MANUAL OF MINOR SURGERY AND BANDAGING, for the use of House-Surgeons, Dressers and Junior Practitioners. By Christopher Heath, F. R. C. S., Surgeon to University College Hospital and Holme Professor of Clinical Surgery in University College, London; Member of the Council of the Royal College of Surgeons of England. Tenth edition. Illustrated, 16mo. pp. xvi.—389. Price, $2.00. Philadelphia: P. Blakiston, Son & Co., 1894.

A book that has reached its tenth edition needs very little notice. In this volume the principal change has been a revision of the chapter on antisepsis. As all who have used this book know, it is an exceedingly valuable reference work and treats of almost every conceivable emergency case, as well as giving a clear course on bandaging. The illustrations are numerous and in the right place.

REPRINTS, ETC., RECEIVED.

Transactions of the Medical Association of the State of Missouri, 1893.

Transactions of the Medical Society of the State of North Carolina, 1893.

Transactions of the American Dermatological Association, 1894.

Second Annual Report of the Sheppard Asylum, 1894.

Annual Report of the Health Department of Baltimore, 1894.

Twenty-sixth Annual Report of the New York Orthopedic Dispensary and Hospital, 1894.

A New Spigot Attachment to Facilitate Asepsis; by Hunter Robb, M. D. Reprint from *Annals of Surgery*.

A New Dynamometer for Use in Anthropometry. By J. H. Kellogg, M. D. Reprint from *Modern Medicine*.

The Limitations for the Use of the Pessary. By Hunter Robb, M. D. Reprint from MARYLAND MEDICAL JOURNAL.

The Works of Justine Siegemundin, the Midwife. By Hunter Robb, M. D., Associate in Gynecology, Johns Hopkins Hospital. Reprint from *Johns Hopkins Bulletin*.

A Plea for the Early Treatment in Ear Diseases. By Edward J. Bernstein, M. D., of Baltimore. Reprint from MARYLAND MEDICAL JOURNAL.

Cosmetics. By Robert B. Morison, M. D., Baltimore. Reprint from the *Journal of Cutaneous and Genito-Urinary Diseases*.

On Guaiacol Applied Externally as an Antipyretic. By Julius Friedenwald, A. B., M. D., and H. H. Hayden, M. D. Reprint from the New York *Medical Journal*.

The Direct Examination of the Female Bladder with Elevated Pelvis. The Catheterization of the Ureters under Direct Inspection, with and without Elevation of the Pelvis. By Howard A. Kelly, M. D., Professor of Gynecology, Baltimore. Reprint from the *American Journal of Obstetrics*.

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The Index to Volume XXX of this Journal will be distributed to subscribers and others later.

NOTES.

One of the latest antiseptic ointments is called boroline ; it is composed of boracic acid and lanolin, and is said to be an excellent lubricant and emollient in obstetric practice.

*

Chemists have at last succeeded in getting out a pure crystal of guaiacol. Heretofore there had always been about ten per cent. of creosote present. It may make little difference therapeutically, but a pure drug is always to be preferred.

*

Lémanski in the *Lyon Médicale* says that salicylate of sodium in a suppository is well borne and should be so used when it cannot be tolerated by a delicate stomach. Fifteen grains should be rubbed up with enough coca butter and given three to six times a day.

*

Dr. Sangree advocates the application of ice to the root of the neck over the course of the pneumogastric nerve in severe bronchial spasm. He says in the *Bullétin Générale de Thérapeutique* that in a few minutes after the application of the ice the spasm will stop and the patient will sleep. Such a simple method is worth trying even if it fail.

READING NOTICES.

Headache in childhood is rapidly relieved by Celerina in doses of ten minims four times a day.

*

Thomas W. Webb, L. R. C. P., L. M., 33 O'Connell street, Waterford, Ireland, says: It affords me great pleasure in saying that I have had signal success with Cactina Pillets in various forms of heart disease, in alcoholism, excessive tobacco using, more especially chewing. Cactina Pillets are invaluable.

*

T. D. Finck, M. D., Kentucky School of Medicine, Louisville, says: "I am convinced there is no remedy so useful and attended with such satisfactory results in the treatment of melancholia with vasomotor disturbances, anemic headaches, emotional distress and active delusions of apprehension and distrust, as antikamnia. It also increases the appetite and arterial tension, as well as being particularly serviceable in relieving the persistent headache which accompanies nervous asthenia."

*

Habitual Miscarriage.—M. D. Makuna, M. R. C. S. Eng., Lic. Med. University, Bombay, 1876, Trebeebut, Rhondda Valley, South Wales, says: I have much pleasure in expressing my satisfaction with the results I have obtained by the use of Aletris Cordial. One of my patients, who had miscarried three times previously, took Aletris Cordial during the last three months of pregnancy, and was delivered of a fine healthy boy. I ordered it at her own solicitation, as she expressed so much ease and comfort after the use of the first bottle.

*

Dr. Orazio Satariano, Barrafranca, Italy, says: Although opposed to the use of pharmaceutical specialties, I was struck with the formula of Bromidia (Battle), and knowing the action of its ingredients, could not bring myself to believe in its possessing greater therapeutic power than its component parts. However, I determined to try it in a severe case of mammary neuralgia, which had proved refractory to an infinitude of other remedies. The result was brilliant, and far beyond my expectations. I then made experiments with a preparation made according to the formula of Bromidia, by an experienced pharmacist, but whether due to the greater purity of drugs used, or special mode of combining, the results were not to be compared with those of Bromidia (Battle).

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ORIGINAL ARTICLES.

ACUTE PUERPERAL CELLULITIS AND TRUE PELVIC ABSCESS.

Read Before the Philadelphia County Medical Society, April 11, 1894.

By Charles P. Noble, M. D.,
of Philadelphia.

It is my purpose in this communication to report my experience with acute puerperal cellulitis and true pelvic abscess, collecting together in one paper the various cases which I have reported from time to time. The time has now come when such a communication will be received in a proper spirit—that is, as a report of conditions carefully observed at the bedside, and therefore as a contribution to scientific medicine. The first whirl of excitement which followed the discovery of the real nature of chronic pelvic inflammatory troubles has passed by. Men are no longer blinded by the prejudices of the era when all pelvic inflammation was regarded as cellulitis. A sufficient time has now elapsed to enable them to recover from the reactionary wave, during the height of which it was believed that all pelvic inflammation was necessarily tubal in origin. Practitioners of medicine are very prone to be ruled by the dogmas of a few leaders in professional thought, and gynecologists are no exception to this rule. During two generations they gave implicit adherence to the dogma of Nonat, Churchill and Emmet, and during the present generation no less implicit adherence to that of Tait and his disciples. It is now time to accept all the facts in the case whether or not they agree with prevailing theories.

Case I.—This patient I saw operated upon May 8, 1888, by Dr. D. Longaker, who gave me the following history: Mrs. F., aged twenty-six years, III-para. She was delivered of the third child seven weeks ago, by a natural and easy labor. On the fifth day she had a chill, and chills and fever continued thereafter, also great pain. Dr. Longaker saw her seven weeks after labor, and operated for a clearly defined mass situated mostly in the left side of the pelvis, rising up above the brim of the pelvis and extending from the symphysis pubis to the iliac crest. An exploratory cœliotomy showed that both uterine appendages were of normal size, but were somewhat fixed by recent adhesions; "neither right nor left ovary nor tube formed any part of the mass; these structures could be distinctly outlined apart from it." Fluctuation was distinct in the swelling as made out by the intra-abdominal finger. A second incision was made above Poupart's ligament, and about half a pint of pus was discharged. The pus cavity

was located in the left broad ligament, and extended between the uterus and bladder into the right broad ligament. The patient made a good recovery, but has borne no children since. This is probably because effectual means were taken thereafter to prevent conception.

Case II.—This patient was seen at the Philadelphia Lying-in Charity during my service there as senior assistant physician. I am unable to find any published notes of the case. My recollection of its salient points is very clear and distinct. This patient was infected after labor, and after a number of days presented the usual evidences of suppuration, together with the signs of intense inflammation in the right side of the pelvis and in the right inguinal region. A hard mass of exudate formed in the right groin, which could be distinctly outlined by palpation. There was every evidence that this was a case of true pelvic abscess, but influenced by the teaching that all pelvic suppuration is intra-peritoneal, an abdominal section was made by Dr. Charles Meigs Wilson, assisted by myself. The uterine appendages were carefully examined, and it was evident that the pus accumulation was entirely distinct from them, and that it was external to the peritoneum. The abdominal incision was closed and the pus let out by an incision made above Poupart's ligament, near the anterior superior spine of the ilium. This patient made an uninterrupted and quick recovery.

Case III.—This case I saw in consultation with Dr. Himmelwright, March 2, 1890. The history, as given to me by Dr. Himmelwright, is as follows: The patient had a miscarriage, January 3, in the second month of pregnancy. One week later, symptoms of pelvic inflammation appeared, and a diagnosis of peritonitis was made. The patient got about by February 1. After a week, pain was felt in the right inguinal region, and gradually increased in intensity, extending to the lumbar region.—After another week (February 15) she was unable to walk erect and put her foot firmly on the ground, but had to stoop forward. During this time the temperature remained normal and there were no chills. At times the pulse was slightly accelerated. The pain continued to increase, and, on February 27, a swelling was noticed in the right lumbar region. March 1, the temperature rose to 101° F., and the pulse to 120, and there were slight chills. March 2, I saw her. The temperature was normal, the pulse about 90. The right inguinal region was tender, suggesting, indeed, appendicitis, but there were no symptoms to warrant the supposition. A semi-fluctuant swelling was found in the right lumbar region. The next day this swelling had increased, and a hard mass was felt in the right inguinal region, extending as high as the ribs. The swelling in the lumber region was opened and two or three pints of pus escaped. Introducing my index finger, it passed around the ilium into the iliac fossa. A rubber drainage-tube was introduced, and irrigated daily with a dilute solution of peroxide of hydrogen. This discharge gradually decreased and the tract rapidly healed, closing from the bottom.

It may be asked: "Why is this claimed as a case of true pelvic abscess?" The abscess was undoubtedly situated in the false pelvis on the right side. I had my finger in it. The entire absence of bowel symptoms excludes perityphlitis. The fact that, on examination, the uterus was found movable and the broad ligaments free from exudate—no fixation of the appendages—excludes pyosalpinx. Hence, I take it, the abscess was due to the breaking down of an infected pelvic gland situated behind the peritoneum, in the right iliac region.

Case IV.—This case was in every way similar to the first. I saw the patient in consultation with Dr. Langrehr, five weeks after labor. The perineum had been torn, and was sutured some hours after labor. Septic infection occurred, and for three weeks the temperature ranged between 100° F. and 103° F. During this time there was no pain or distention of the abdomen, or tenderness of the uterine appendages on examination. The perineal wound became

inflamed, however, and the stitches were removed. During the fourth week all the symptoms abated. At the beginning of the fifth week the fever increased and tenderness in the left inguinal region became marked. Purulent matter had been discharged *per vaginam*, but whether or not it came from the abscess which had formed was questionable. On examining the patient five weeks after labor, I found her much depressed, in a typhoid condition, with a swelling above the pubes and to the left. Under chloroform a mass of exudate was felt in the left broad ligament extending between the uterus and the bladder, and plainly palpable above the pubes. My diagnosis was true pelvic abscess. I advised median section for an absolute exclusion of complicating pyosalpinx; then a second incision parallel with Poupart's ligament, to evacuate the abscess. This was done by Dr. Langrehr on the following day. The uterus, ovaries and tubes were found healthy. The omentum was, in places, densely adherent. The abscess was situated within the broad ligament, and extended upward behind and two inches above the ramus of the pubes. It contained about six ounces of thick pus, which was evacuated by an incision in the left inguinal region, directly above Poupart's ligament. The ultimate recovery was perfect.*

Case V.†—Mrs. G., aged thirty years, II-para, was delivered January 18, 1893, of a living child, after a normal labor. The placenta was delivered by the introduction of the hand. The following day Mrs. G. had a temperature of 104° F., and was suffering much from pain in the right groin and from tympany. On the night of January 20, I saw her in consultation. The temperature was 103° F., the pulse 110, and there was marked tympany and much tenderness in the right groin. A striking feature in the case was that, although the bowels were very much distended, the abdominal wall itself was not very tense. The coils of distended bowels could be very plainly observed through the abdominal wall. The bowels had not been moved for four or five days. The patient was put upon quinine, strychnine and digitalis, and the bowels were freely moved. Vaginal and intra-uterine douches of corrosive sublimate were employed, although the lochial flow was not foul-smelling. The patient's condition remained very much the same until the seventh day, when the right broad ligament became infiltrated, so much so as to be plainly palpable above the brim of the pelvis in the right groin, while from below the anterior and right quarter of the pelvis was filled with exudate closely attached to the pelvic wall and displacing the cervix backward into the hollow of the sacrum. This exudate began to disappear about the fourteenth day, and was absorbed very rapidly. Convalescence was further interrupted by a nephritis, possibly of septic origin, and also by severe intestinal pain accompanied by diarrhea, presumably due to inflammation of the large bowel. This patient was seen in consultation by Drs. Goodell and Parish. She eventually made a good recovery.

Case VI.—Mrs. H., aged twenty-eight years, II-para, was delivered of her second child in March, 1891, the labor being conducted by a midwife. She was infected and was extremely ill. I saw her with Dr. Leopold five weeks after the labor. At that time she was prostrated, with a rapid pulse, "leaky" skin, chills, irregular temperature—in fact, the classical symptoms of septic intoxication.

On examination the right broad ligament was found indurated and a mass of exudate extending on the right side of the abdomen almost as high as the umbilicus. From the extent of the *mass* it was supposed that a right pyosalpinx with an intra-peritoneal abscess existed; but in view of the puerperal history and the existence of a cervical laceration the possibility of a true pelvic abscess was discussed. A median abdominal incision was made April 16, and the abdominal viscera in the lower right quarter of the pelvis was found fused by adhesions.—The patient took ether so badly, becom-

*The first four cases have been reported in the *Medical News*, of August 29, 1891.
†Annals of Gynecology and Pediatry, June, 1893.

ing cyanosed while still partly conscious, and the pulse was so weak, that I and the gentlemen present were convinced that to attempt the separation of the adhesions, and the evacuation of the pus from above, would result in her death on the table from ether. An unsuccessful attempt was made to reach the pus by an incision made near the anterior superior spine of the ilium without giving more ether. The exploration was not pushed, owing to the patient's bad condition. The patient was then put to bed and improved for some days. Operation was again proposed and chloroform selected as the anesthetic, which produced as much cyanosis as ether had done. An incision was now made directly over the broad ligament, the uterus was located, and the index finger was forced into the broad ligament, evacuating several ounces of pus. With rubber drainage a satisfactory convalescence followed.

October 27, 1892, I operated on Mrs. H. to cure a ventral hernia which had formed at the site of the third incision. On opening the abdomen I was surprised to find that the adhesions throughout the right side of the abdomen, which had been universal eighteen months before, had disappeared, except a point of adhesion between the omentum and hernial sac, and another between the omentum and broad ligament. Both appendages were perfectly healthy. This fact demonstrates what was believed when the pus was evacuated, namely, that it was not a pyosalpinx, but an abscess of the broad ligament.

The disappearance of the very extensive adhesions in this case is worthy of record as showing that peritoneal adhesions are not necessarily permanent.

It is of interest to report that during the summer of 1893 this patient was delivered of a living child after a normal labor, and that she is at present in good health.‡

Case VII.—Mrs. F., aged eighteen years, was confined May 8, 1893. She had a mild puerperal sepsis and was in bed for two weeks. The following month she was constantly sick, being in and out of bed, suffering with pelvic pain, anorexia, and having more or less fever. (The temperature and pulse I do not know, as I was not in attendance.) She came under my care six weeks after her confinement, and was admitted to the Kensington Hospital for Women. Examination showed a large inflammatory mass in the pelvis, absolutely anchored to the left pelvic wall. She was under observation for two weeks, with the temperature fluctuating between 99° and 102° F., with the general evidences of mild septic absorption, such as anorexia, sweats, chilly sensations, and increased pulse-rate.

Believing that pus was present in the pelvis, either in the form of a true pelvic abscess or a pyosalpinx, an abdominal section was made on June 26, 1893. The following conditions were found: The uterus was fairly well involuted and was displaced upward and backward by a mass in the left broad ligament. The right broad ligament and the right Fallopian tube and ovary were entirely normal, as was demonstrated not only by touch but by delivering the ovary and tube through the abdominal incision. The omentum was adherent to the anterior face and upper border of the left broad ligament in front of the Fallopian tube. This adhesion was separated. The left ovary and tube were found to be entirely normal; the meso-salpinx being normal, soft and movable. This was demonstrated not only by touch, but by vision, the woman being in the Trendelenburg posture, so that the entire left side of the pelvis was in plain view. The left broad ligament was very much infiltrated with inflammatory material and firmly anchored to the anterior and left bony wall of the pelvis. Fluctuation was not apparent. It was determined to close the abdomen, and if septic symptoms persisted to open the broad ligament from below. That portion of the omentum which was adherent to the broad ligament was ligated and cut off. A small gauze drain was placed against the broad ligament where the omentum had been separated, so that should pus make its appearance at

‡Reported in Annals of Gynecology and Pediatry, January, 1893.

this point it would find its way out through the abdominal incision.

The patient's convalescence was uninterrupted; the temperature rapidly dropped to the normal, and her general condition steadily improved. The gauze drain was removed, good union of the abdominal incision was obtained and the patient was discharged from the hospital at the end of four weeks. In the meantime, not only had her general condition very much improved, but the pelvic mass had almost disappeared.

This patient consulted me January 9, 1894, to ascertain the cause of a suppression of menstruation of three months. I found her to be between three and four months pregnant. A careful examination of the left broad ligament failed to discover any evidence of the former cellulitis, the left broad ligament feeling exactly like the right one.

The evidence of the existence of acute puerperal cellulitis as a primary condition in this case is absolute. There was not even a complicating pelvic peritonitis in the ordinary sense of that term, merely a point of adhesion between the omentum and the broad ligament, which was, of course, due to a small circumscribed area of peritonitis. I was able to demonstrate these conditions to a number of physicians who were present, including among others Dr. Fullerton, of the Woman's Hospital.

What I wish especially to insist upon is that in this case neither Fallopian tube was involved in the inflammatory process, that both were entirely normal. The left Fallopian tube and its mesentery were scarcely even congested. The circumscribed area of peritonitis where the omentum was adherent to the broad ligament was plainly due to the fact that the inflammation had extended directly through the broad ligament to the peritoneum, leading to the adhesion of the omentum. That this is possible has been denied by those who maintain that all pelvic inflammation is due to infection which has spread through the Fallopian tubes. In this case the conditions present were unmistakable.

We thus have seven cases in all of which, except the third and fifth, an abdominal section was made, so that we have the evidence not only of the usual physical examination, but also that obtained from an intra-peritoneal examination. In Cases I, II, IV, and VII, the abdomen was opened and the uterine appendages were examined, and it was demonstrated that they were either free from disease, or, at the most, lightly attached by recent adhesions. In these four cases there is not a shadow of a doubt that the disease was in the broad ligament, and that it spread to the broad ligament directly from the uterus or vagina by way of the lymphatics.

Case VI was undoubtedly not a case of pyosalpinx, and I have no question myself that the pus was located in the broad ligament. A carping critic might affirm, that even although it was not a pus tube, the pus was intra- and not extra-peritoneal, and that it was due to suppurative peritonitis. My opinion that the pus was in the broad ligament is based upon the fact that the pelvic exudate was anchored to the anterior and right pelvic walls, and that when I cut down upon the mass I recognized the uterus and tore through the broad ligament with my finger in front of the Fallopian tube.

The evidence in Cases III and V is not so absolute as in the others, and they are included in this list not for the sake of *demonstrating* the occurrence of puerperal cellulitis, as is done by the other cases, but because of their relative bearing upon the subject.

The foregoing cases demonstrate several interesting facts with reference to obstetrics and gynecology:

1. That in the puerperal state, pelvic cellulitis and true pelvic abscess occur as the result of septic inflammation.

2. That inflammation may spread from the vagina or uterus along the pelvic lymphatics to the broad ligaments without involving the Fallopian tubes.

3. That peritonitis can be set up by the spread of inflammation from the broad ligaments to the peritoneum without involvement of the Fallopian tubes.

4. That very extensive pelvic exudate and intra-peritoneal adhesions can be absorbed.

It hardly seems worth while to bring evidence to bear in support of our first proposition, and it would not be called for were it not that a few men of wide experience maintain the contrary. Being able to present absolute evidence in the shape of carefully and thoroughly observed cases occurring in my own practice, I shall not take the time or trouble to make reference to the literature.

What I have said concerning proposition one is equally true of proposition two, which is distinctly proven by certain of the foregoing cases. Case VII is a beautiful illustration of the fact that a very extensive puerperal cellulitis can be present and yet the Fallopian tubes be entirely healthy. In this case they were scarcely, if at all, congested, and the meso-salpinx was entirely free from infiltration.

The third proposition is likewise proven, especially by Cases IV and VII. In both of these cases the omentum was adherent to the broad ligament, although the tubes were free from disease. I have no doubt that pelvic peritonitis is usually due to the spread of inflammation from the endometrium through the Fallopian tubes to the peritoneum, but these cases show that this rule is not without exceptions. Numerous other exceptions have come under my observation. For instance, a short time ago I did a hysterectomy for a fibroid tumor, in which the tumor, being impacted in the pelvis, was adherent to the rectum and posterior pelvic wall, over an area of at least nine square inches, and yet in that case the Fallopian tubes were entirely normal. In several cases of appendicitis I have found the peritonitis to extend to the pelvis, the Fallopian tubes having nothing to do with its occurrence. Moreover, it is a well-known fact, that when small tumors, especially dermoids, become wedged in the pelvis, or become twisted upon their pedicles, that peritonitis ensues. Likewise, that in cases of malignant disease of the abdominal or pelvic organs, adhesions are almost always present. Therefore it must be admitted that pelvic peritonitis can occur independent of salpingitis.

Case VI demonstrates our fourth proposition. In that case the entire right lower quarter of the abdomen was fused together by recent peritoneal exudate, and light adhesions had formed in the left half of the pelvis, yet 18 months later, when the abdomen was re-opened, the entire mass of adhesions had been absorbed, with the exception of a small point between the omentum and right broad ligament, and another small point between the omentum and the hernial sac. Owing to the very extensive character of the adhesions in this case, it is a striking example of the fact that recent adhesions can be entirely absorbed.

Two women of the seven whose cases have been detailed in this report have been delivered of living children since their recovery from the attack of acute puerperal pelvic cellulitis.‖ The subsequent history of four of the other five women is unknown to me. The fact that two of these women have borne children is of interest because of its bearing upon the question of the relation of pelvic exudates to sterility. As this paper has dealt only with demonstrated facts, I shall merely suggest that the occurrence of pregnancy after the existence of extensive exudates, forming during the puerperal state, is best explained in many cases by the fact that the condition present is a puerperal cellulitis rather than a diseased tube. It is a severe tax upon my credulity to accept the statement that extensively diseased tubes, more especially pus tubes, can so far recover as to permit the occurrence of pregnancy; and I believe that the true explanation in not a few cases of pregnancy following the recovery from puerperal pelvic inflammation is, that the disease was originally in the broad ligament and not in the Fallopian tube.

In conclusion, I wish to say a few words concerning the relative frequency of acute puerperal cellulitis and inflammation of the Fallopian tubes. I believe as firmly as any one that pelvic cellulitis and true pelvic abscess are comparatively rare conditions, and that the usual variety of pelvic inflammation is a

‖ Since writing this article I have learned that Dr. Himmelwright's patient (Case III) has been delivered of a living child, after a normal labor.

salpingo-peritonitis. I have not met with pelvic cellulitis except in the puerperal state, and have no reason to believe that it occurs in the non-puerperal state, except as a result of infected wounds of the vagina and perineum. As such conditions are very infrequent, a pelvic cellulitis in the non-puerperal state would be a surgical curiosity.

I have added these remarks lest it might be inferred by the unthinking that I am desirous of supporting the old and abandoned theory of Nonat and Emmet concerning pelvic inflammation. At the same time I am glad to be able to present incontestable proofs of the occasional occurrence of acute puerperal pelvic cellulitis and true pelvic abscess.

PREDISPOSITON TO PHTHISIS.

THE ANNUAL ORATION DELIVERED BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 26, 1894.

By James T. Whittaker, M. D.,
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PFEIFFER states a well-known fact when he says that children of tuberculous parents are often sickly from birth. Affections of the mucous membrane are unusually virulent and obstinate, and complications are more wont to develop. For instance, in such children there is with every simple catarrh of the throat an inflammation of the ear, "not only once, but every time, and not only in one child of the family, but often in every one." Sometimes it seems that this disposition may skip individual generations, since such diseases are observed in children whose parents have been sound, but whose grandparents or more remote ancestors suffered with tuberculosis. How much prejudice may influence an opinion is seen from the conclusion which this author draws that "the presence of predisposing circumstances must be accepted in spite of the fact that in an extraordinarily large number of autopsies we found the remains of a more or less extensive tuberculous disease in the form of caseous or calcified deposits in the lungs, in the lymph glands, in cicatricial atrophy of the apices, proving that tubercle bacilli were once present." The author seems to be unaware of the disclosures of Ziemmsen, who found living bacilli in apparently quiescent cervical glands, and of Loomis, who reported of 763 autopsies, 71 cases apparently cured, the patients having died of different diseases. The cure was effected by the usual marked increase of connective tissue, but that the cure was not always so perfect as appeared to the naked eye was demonstated by the discovery of tubercle bacilli in three of the twelve lungs examined.

Of the affections of the ear, which are so prone to occur, tubercle bacilli have been already actually demonstrated in half the cases. Here, too, the sickliness of the child is the effect and not the cause of the tuberculosis.

Independent of inheritance altogether, the tendency is said at times to be acquired, and the same factors have been invoked, to wit, the paralytic thorax, the phthisical habitus, the frequent occurrence of catarrh, defective ciliary action, hypoplasia of the heart, etc. The statement rests upon the same evidence as in the case of the inherited tendency, but more may be claimed perhaps for a chemical alteration of the juices or organs of the body, which may fertilize the soil for the growth of the tubercle bacillus, or what is more likely true, lessen resistance to its invasion. Such a change certainly takes place in diabetes. It is a a notorious fact that one-half of the cases of diabetes succumb to tuber-

culosis. Seegen found the lungs sound in diabetes in only a few cases. Leyden found a latent development of phthisis under insidious general symptoms especially remarkable in cases of diabetes, and usually under the entire absence of hemoptysis. In what this alteration consists we do not know, but studies in culture soil may throw some light upon this obscure subject. Sander found that a somewhat acid culture soil is the most favorable to the growth of the tubercle bacillus. This author observed also that growth occurred in neutral soils with the addition of glycerine. Here may be mentioned for what they are worth the experiments of Fermi and Salsano, who found that the long continued injection of dextrose and lactic acid into the bodies of guinea-pigs and mice increased the disposition to tuberculosis. All these conditions are found in diabetes, but that the predisposition is not peculiar to phthisis is shown from the fact that the diabetic patient is also especially liable to invasion by other micro-organisms, especially those of pus, as furunculosis is almost as common as tuberculosis.

I would like to begin the next section of this subject with the statement, which may not now be gainsaid, that tuberculosis depends solely and exclusively upon the tubercle bacillus. The tubercle bacillus is the one over-shadowing fact in the whole history of this disease. It is the nucleus about which everything else must crystallize. As the true believer would say, when everything else is in doubt this is the rock to which we cling.

Everything must conform to the tubercle bacillus. Whatever fails to fall in with this view is relegated as useless lumber to the ancient history of the disease. It illuminates a whole field of obscure diseases. It reconciles discordant facts. It establishes unity. For instance, it is a far cry from a basilar meningitis to a hip disease, from an otitis to an orchitis, from a miliary affection to an Addison's disease, from a lupus vulgaris to a fistula in ano. Tuberculosis is conveyed by infection, because it is conveyed by a living thing which grows only from itself. It belongs to the older civilizations, and is unheard of and unknown among newer peoples, as among the Australians, or our own Indians, until it was brought to them by Europeans. Tuberculosis is therefore most frequent in those organs which are most exposed to the outside air. Louis, long before the cause was known, declared it to be a law that if tuberculosis is found elsewhere in the body, it will always be found in the lungs. In fact, tuberculosis is found first in the lungs, next in the intestines, and in the lymph glands, as it is absorbed from these organs, and then and thence in other organs and tissues of the body. To this point we return again.

Tuberculosis is most frequent and intense in the most closed and crowded spaces. A sentence of imprisonment for any number of years is a condemnation to death by tuberculosis. Cornet has shown that sixty per cent. of nurses succumb to tuberculosis. It is useless here to dwell upon this fact. No one now refuses to believe that tuberculosis of the lungs is acquired by inhalation of the tubercle bacillus. Even the exceptional case of inheritance is by infection of the ovum and in this case it is impossible to conceive that the mothers too came from an infected ovum. The problem is to solve the individual case of exemption with the same environment. It is alleged against infection that many individuals exposed all their lives long fail to contract the disease. But the same thing has been said repeatedly of diseases infectious by universal acceptance—typhoid fever, for instance. Watson said long ago of variola, "There is no contagion so strong and sure as that of small-pox, and none that operates at so great a distance." But three of the great masters of medicine in the olden time, Morgagni, Diemerbroeck and Boerhaave, who walked among epidemics unscathed, believed that the disease was little or not at all contagious. Then it is urged that cases have not multiplied in places to which tuberculous patients have been sent in numbers.

Attention is often called to the fact that the disease has not diminished in Naples, where failure of registration of

cases was punished with a fine of 300 ducats, and, on repetition, with banishment for ten years. For fifty-six years this decree was rigorously enforced with indescribable damage to the community, according to de Renzi, and according to Brehmer, entirely without influence upon the frequency of the disease.

Römpler reports of his fifteen years observations in Görbersdorf, that the emigration of patients had not increased the number of cases among the indigenous in that village. In the last hundred years only 72 persons died of tuberculosis among a thousand from all causes, and the disease successively diminished in the last four decades notwithstanding the increased overflow of the place with lung disease.

The observations to the same effect made at the Brompton Hospital, which seemed to show that the disease was never contracted in these institutions, have been invalidated, partly by the subsequent discovery of cases, the men remaining alive or even in apparent health is not evidence of exemption, and partly by the studies of Cornet, who showed the cleanliness of institutions, *i. e.*, freedom from infectious dusts as compared with private houses.

Tuberculosis deposited in the recesses of the body is preceded by deposits in the course of the main avenues. Mention has been made already of deposits in the bronchial and in the mesenteric glands. The disease irradiates from these centers. Sometimes the primary deposit is more concealed and the disease is disseminated from some cryptogenetic source.

Plain cases and curious cases of all kinds abound in literature. Thus Spengler found tubercle bacilli in the bronchial lymphatics of six children who had died of diphtheria, sepsis, etc., but who had shown no symptoms of tuberculosis. With one exception this was the only place where tuberculosis was present. The bacilli had clearly penetrated from the respiratory mucous membrane. Neumann, from his studies, concludes, as stated already, that the bronchial glands are the first depots of deposit in children. The inhaled bacilli are carried to the nearest gland and may here either be destroyed, or after a variable time, owing perhaps to some intercurrent affection, "measles, pertussis, bronchitis, inflammation of the lungs," may be carried to any part of the body to produce the various tubercular affections. Babes found affection of the bronchial glands in the children's hospital at Buda-Pesth in more than half his sections. Müller, of Munich, found the same condition 103 times in 500 sections. Northrup, of New York, found caseation limited to the bronchial glands forty-two times in one hundred and twenty-five cases. In three cases only was the primary infection in the mesenteric glands. Engelnäh made a bacteriological examination of the lungs, bronchial and mesenteric glands in one hundred and twenty infants, which died at a St. Petersburg hospital during six weeks of the fall of 1891. Tubercle bacilli were found in fourteen cases (11.7 per cent.) at ages varying from two months and four days, the youngest to seven months and seven days. They were present in both the lungs and bronchial glands in 93 per cent. of cases.

Neumann goes so far as to say that children who have died of tuberculosis of any organ always show affection of the bronchial glands, and that affection of the bronchial glands depends always on infection with tubercle bacilli. But in the few established cases of fetal tuberculosis, the bronchial glands were not at all or only very insignificantly affected.

Again, the anatomical situation of the glands indicates infection by inhalation. Buchner and Wyssokowytsch showed in their experiments that the inhaled spores of various bacteria could penetrate to these glands without lodging in the lungs. From these glands the bacilli irradiate.

According to Weigert, miliary tuberculosis of the lungs is a consequence of invasion of the pulmonary veins from the intra-pulmonary glands. In nearly all these cases, the exemption of the mesenteric and cervical glands is proof of the fact that the avenue was through the lungs.

The exceptional cases are sometimes very curious. Thus Jaccoud and Schürhoff each furnished interesting contributions to the origin of acute miliary tuberculosis. In the case of Jaccoud, the miliary tuberculosis occurred in the course of a hemiplegia, and its origin was from an old tuberculous deposit in the brain without meningitis. In the case of Schürhoff, the military tuberculosis arose from a tuberculous nodule in the mitral valve, which in turn had developed from an old pericarditis. In a case reported by Köbner, there developed, besides a laryngeal phthisis, an extensive tuberculous destruction of the skin of the chin. This patient had been shaved for many years in different barber-shops, all the time carrying about a suppurating wound. In the case of Rethi, there developed, after the extraction of a tooth, a tuberculous ulcer of the mouth, which led to extensive destruction with further communication with the cavities of the mouth, nose and jaw. Hilbert reported a case from Königsberg in which the tuberculous meningitis developed immediately after a violent concussion of the head, as tuberculous disease often does in other places. I know myself of two cases of basilar meningitis after trivial trauma. Mordhorst long ago called attention to the opportunity offered for the colonization of bacilli in the quiet regions of extravasated blood after trauma. Heiberg reported 84 cases of uro-genital tuberculosis most frequently as a sequence to bone and joint disease. Dittrich reported 16 cases of tuberculous perichondritis of the cartilages of the ribs. The majority of the cases suffered from easily demonstrable tuberculous affection elsewhere. A case reported by Frankenburger of Nüremberg died of acute military tuberculosis, and the only lesion found post-mortem was an old tuberculous disease of the uterus and tubes. Radcliffe mentions cases in which tuberculosis of the lungs ran a favorable course. The patient seemed perfectly well for years, and then began to show the insidious signs of a chronic nephritis, due to the direct penetration of the kidneys by tubercle bacilli.

It is not necessary to appeal to ancestral history in explanation of these cases. The ancestry of the disease is found in the individual himself. There is no real immunity. Cornet has shown that when a number of animals are subjected to inhalations of atomized sputum, some are affected and others escape. If the inhalation is more prolonged they are all affected with one or two exceptions, and if then it is still more prolonged, the exceptions are also affected. Why is this difference in time? This much only may be said, that if these animals are reduced by different diseases, the differences are still more marked, and this is the truth about the predisposition in man, that is, there is no disposition peculiar to phthisis and there is no immunity to phthisis. Pathetic proof of this fact is often enough furnished by careless individuals. During the inhalation experiments of Tappeiner, his assistant, a remarkably robust and vigorous man of forty years, free from all hereditary taint, and previously in perfect health, could not be restrained from entering the apartments, boasting of his ability to show his strength and the lack of danger of this procedure. He continued to enter the rooms in defiance of entreaty and command. He fell a victim in the course of fourteen weeks to phthisis florida, and autopsy revealed exactly the conditions that were found in dogs killed in the same way. Cornet tells the story of a clerk who asked his employer to supply the office with cuspidors. "If you have hectic, we don't want you," he said, "if not, you don't need them." This brutality met its reward. In six months the employer had hectic himself.

The attempt to deduce conclusions from the laboratory is often greeted with contumely. It is a common saying, especially among clinicians of the old school, that a man is not a test tube. The fact is he is a test tube, enclosed in skin instead of glass, but containing a much more complex culture soil. If we do not understand the changes which take place in the culture soil in the interior of his body, it is not the fault of the comparison or the fact. Like the

test tube, he stands about with open mouth and receives what falls into it from the air, and they who believe in predisposition leave him standing helpless without the power of removing the contaminations in the air.

Do you recall the famous test tubes of Tyndall ?

Tyndall exposed one hundred test tubes, ten deep each way, filled with the same solution, fresh urine, to the action of the atmosphere. For fifteen hours the contents remained perfectly clear. This period of clearness he called the "period of latency." We call it the period of incubation. Toward the end of this period the tubes begin to show the effects of disease. The solution passes from clearness to cloudiness in the course of a few hours, but there is a great difference in the tubes. Some are spotted with mould, some are cloudy throughout, some are absolutely opaque. A number of tubes remain apparently unsmitten. Would it be fair to say that the tubes most affected were most predisposed, and that the unsmitten tubes had immunity to attack ? By evening of the next day, under the same exposure, every tube of the hundred was attacked. "The whole process bore a striking resemblance to a plague among a population. The attack being successive and of different degrees of virulence." Test tubes filled with the same fluid sterilized by boiling and exposed to fresh air in a box remained clear for weeks. Was it because these tubes were not predisposed to attack by the bacteria decomposition ?

One of the great arguments adduced against infection is the fact that individuals are said to be most affected in early life, and that age secures exemption. Würzberg showed the fallacy of this view in observations based on studies in Prussia where, of 10,000 persons, the percentage increased from the first decade, which included 10 per cent. regularly to the seventh decade, which included 71. The regiments which made the most campaigns suffered the most, and the few individuals who survived at the end are regarded as invulnerable only by the superstitious.

When it was objected to these conclusions that the statistics were based upon tuberculosis of the lungs alone, which is the most frequent occurrence in adult life, whereas gland and joint affection is more frequent in child life, the objection was met by Zwickh, who showed from the mortality statistics of Bavaria that the general view that tuberculosis is especially a disease of youth is wrong. There is, on the contrary, continual increase of the deaths up to old age. Of 100,000 of the same age, there died of tuberculosis, that is of tuberculous disease of all organs, in the male sex alone, at the

Age.	Number.
6—15	100
16—22	180
21—30	425
31—40	490
41—50	530
51—60	640
61—70	690

When we consider the universality of the disease, we may be led to ask the question, whether the subject of predisposition is not one rather of dissemination in the body of the individual, than acquisition in the first place. This subject opens up the field of invasion by other, especially the pyogenic, microorganisms, which are chiefly responsible for the spread of the disease in the body. Whatever degrades the body in any way favors the development and dissemination of a disease, or any disease, including tuberculosis. In this sense and this only may be admitted a predisposition to phthisis. We may recall in this connection the history of the celebrated rabbits of Trudeau. A number of animals were inoculated with like quantities of the disease. Half of them were allowed to run free in the open air. The other half were supplied with food and drink and immured in a dark hole under ground. The animals were all killed at the same time. Those which had run free had either recovered entirely, or showed only localized lesions. The immured animals showed wide dissemination of the disease. Would any one say that these immured animals were more predisposed to the disease ? The weak

and feeble from whatever cause are the victims of all disease. Birch-Hirschfeld long ago showed that the mortality at the end of the year is not increased by the prevalence in its course of any epidemic. The epidemic numbers its victims among those who would have died of other cause.

It has been shown, I think, that the theory of a predisposition is dangerous, in that it removes attention from the avoidable sources of the disease. It is also undemonstrable, and experiments made to prove it are all open to objection. Finally, it is superfluous. A predisposition is a return to the assumption of a diathesis which excites a horripilation in a man of modern education. Like the doctrine of predestination, to its opponents it takes away the chance of rescue. Do you believe that a man is predisposed to syphilis? These diseases were for a long time studied together. Tuberculosis is acquired by infection. Ignorance of this fact favors the spread of the disease. I have more than once made this experience. I have been called to see a case often in a tenement-house, sometimes in an under-ground room, found the patient lying in bed in last stages of phthisis, unable to lift his head to expectorate, the floor about the bed covered with newspapers, saturated with sputum which he had projected in a parabolic curve. The condition of the bed may be surmised. In this same room, not infrequently the wife or mother was washing clothes, some of which were hung up to dry, so that the air was saturated with steam, and in this same steam-heated, polluted atmosphere, little children with half-naked bodies were picking their way about the room with bare feet. When in the due course of time, these little children, thus inoculated, showed some of the localizations of tuberculosis, they would not have to travel far to find a physician who would dub the disease hereditary, and resign himself to the hopelessness of the situation. Once I found a patient in somewhat higher life lying back in a wheeled-chair, which had been rolled close to a red hot anthracite stove. Surrounding the patient and the stove was a clothes-horse upon which were suspended a number of handkerchiefs and cloths. I asked the patient what they were. They said they were the cloths used for the reception of sputum. They did not need to be washed out, because the sputum was watery and clear. The man who would enter and stay in that room with a full knowledge of its dangers is braver than the heroes at Balaklava.

The ancient views regarding the nature of phthisis die hard. The London *Lancet* of the present day opposes the classification of tuberculosis as an infectious disease. This I read in a recent number: "If phthisis is to be definitely scheduled as an infectious disease in our Statute-book, and to become amenable to all the provisions regarding infectious diseases in the Public Health Acts, it is hardly possible to contemplate the result without some misgivings. Let us take, for instance, the case of a conscientious young man just about to enter life, and who is considered by his medical adviser to be manifesting the signs and symptoms of phthisis. The case is in due course notified, and the patient becomes in his own eyes a leper destined to an early death, and in the eyes of the community a danger to the public health. More than this, he would, if our supposition be correct, be in constant dread of the Public Health Act of 1875, and the Infectious Disease (Prevention) Act of 1890; his chances of marriage would have vanished forever, and the insurance societies would refuse to consider his proposal. If, too, his removal to some isolated hospital was insisted upon and he was allowed with a constant accompaniment of a spittoon, provided with a disinfectant, to travel for the benefit of his health, he would nevertheless feel bound to notify his leprous condition to all hotel-keepers, so that disinfection of his room might be properly carried out. Add to this the by no means impossible circumstance, that the diagnosis was erroneous, or that the patient recovered, at any rate for a time, and we have some faint indication of the result of dealing with phthisis as an infectious disease."

Suppose we now substitute gonor-

rhea or syphilis or small-pox or diphtheria in this reading and for the spittoons, towels; would the statement excite sympathy or aversion?

But it is impossible to imagine a grosser misrepresentation of facts. To begin with, this view overlooks the simple fact that knowledge is power; that the recognition of the disease is in nearly all cases more absolute than that of scarlet fever, small-pox, or syphilis; that phthisis is acquired chiefly by exposure to dried sputum; that the disease in its earlier stages is usually perfectly curable; that nothing about the individual is infectious except his sputum, and that the destruction of the sputum is simplicity itself. The opposition to registration of patients affected with phthisis like opposition to the registration of syphilis, is based upon pecuniary, that is property, reasons, and ethical reasons, and not upon the knowledge which would lead to the extinction or destruction of tuberculosis, that is, not upon the truth as we now know it. For everybody is liable to phthisis. There is no immunity. There is no peculiar predisposition. Predisposition to phthisis is proximity to the sputum of phthisis.

POISONING BY GUAIACOL.

By Julius Friedenwald, A. B., M. D.,

Of Baltimore.

The external application of guaiacol for the reduction of febrile conditions has been given a prominent place in recent medical journalism. It is important, therefore, to direct attention to the toxic symptoms in the first fatal case of guaiacol poisoning.

Prof. Oscar Wyss, of Zürich, reports in the *Deutsche Medicinishe Wochenschrift*, of March 29, 1894, the case of a girl nine years of age, who had been accidentally given 5 c.c. (75 drops) of guaiacol. In a short time she became unconscious; the conjunctivæ became injected, the corneal reflexes diminished and the pupils no longer reacted to light; there were frequent attempts at vomiting and the saliva flowed from the mouth in large quantities. The pulse became rapid, the sensibility of the skin much diminished. Finally the patient began to vomit; the physician detected the odor of guaiacol. The stomach was washed out, but she did not rally. The cyanosis gradually diminished, and instead of it a deadly pallor was observed; the respiration became frequent. Three and a half hours after the guaiacol had been swallowed the patient passed 100 c.c. of brownish-red urine.

The spleen and liver soon enlarged, and the temperature fell to 35.5°C. (96°F.) and small hemorrhages were observed upon the skin of the arms and legs. The urine contained albumen, blood and casts, and Ehrlich's carbolic acid test was positive.

Jaundice soon appeared, the stupor increased and the patient died on the third day.

The autopsy revealed an acute gastritis and enteritis, parenchymatous degeneration of the liver, acute hemorrhagic nephritis, parenchymatous degeneration of the heart muscle, and ecchymoses in the pleura, peritoneum, endocardium and pericardium. The spleen was much enlarged.

Kobert in his text-book on "Intoxicationen" points out that after one gram (15 drops) doses of guaiacol slight appearances of poisoning may supervene. These are characterized by a burning feeling in the stomach, nausea, etc. In one case in which fifteen grams, (three and two-third drachms) were accidentally taken by a patient in the Dorpat Clinic, the stomach was immediately washed out and the patient was rescued. However, unconsciousness set in, the pupils became contracted, the breathing irregular and the intensely dark appearance of the urine was very noticeable.

SOCIETY REPORTS.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

62ND REGULAR MEETING.

The President, Dr. T. A. Ashby, in the chair.

Dr. G. Lane Taneyhill read a paper on PUERPERAL MANIA. (See page 3.)

Dr. Rohé: I want to take occasion to say that I do not agree with the opinion of Dr. Goodell expressed in 1881, or his present opinion, which is just the opposite. The general consensus of opinion is that in the majority of instances puerperal insanity is due to septic infection. I think that opium in any maniacal condition, unless necessary to maintain strength, is bad. Chloral is much better, unless the heart is in bad condition, and in these cases it can be combined with digitalis. Assuming that most cases of puerperal mania are due to sepsis, and that opium is bad in septic condition, I think opium is bad in this disease. Chloral with digitalis, or sulphonal or trional are better.

Dr. Neale reported the following case of PUERPERAL MANIA. Mrs. D., white, 38 years, primipara, delicate, nervous temperament and probably tuberculous. Family history of insanity only on father's side. Patient had recently been under gynecological treatment and complained of a fistula discharging into the vaginal entrance, the orifice of which I could not find at my first and only examination made before confinement. I was summoned to attend her in labor at term during afternoon of May 27, 1885. Pains at first scarcely appreciable, gradually increased and the slow, tedious labor was terminated naturally at 12.20 P. M., May 29, 1885. A slight perineal laceration was sustained. After labor patient continued very restless, complained of pain in the chest and abdomen, vomited and did not sleep until four one-fourth grain doses of the sulphate of morphia had been given hypodermically at intervals of one hour. She was delivered at 12.20 P. M. and at 10 P. M. the temperature was 100.1-5°, pulse 112, respiration 24. After a restless night, I found her next morning, May 30, with temperature 102°, pulse 112, respiration 24 and complaining of pain in the chest and abdomen, for which no local cause could be found.

At 2 P.M., May 30, nearly 26 hours after delivery, a maniacal attack occurred and the patient screamed out with pain in the chest and abdomen and also loudly shrieking, "My back is breaking," she became violently maniacal, voiding urine freely in bed. I at once gave her ten minims of Magendie's solution hypodermically, which was followed by sleep. Upon immediate consultation with Prof. Miltenberger, puerperal septicemia complicated by mania was diagnosed and the patient was given twenty grains of chloral every two hours according to the effect produced. Sleep followed throughout most of the night, but she was maniacal whenever awake.

May 31, A. M. temperature 100.2-5°, pulse 112, respiration 24. Patient conscious and better. Mania recurred during the morning, however, slight tympanites developed, lochia became scanty and tainted and temperature and pulse gradually increased. The uterus was washed out, quinine was given internally, together with liberal stimulation and morphine according to mania, sleeplessness, etc., but she sank and died at 6 A.M., June 1, 1885.

Dr. J. Edwin Michael: I have seen only one case of puerperal insanity; it was due to sepsis, had symptoms of melancholia and finally recovered. She was treated with bromidia. I agree that these cases are associated very often with sepsis, but that does not account for all of them; heredity is no doubt a very powerful causative agent. We should remember that women who have a hereditary taint may be attacked during the puerperal period.

Dr. Wilmer Brinton: I have seen three cases; all went to institutions for the insane; all died. One case had mania in her first confinement and recovered. With her second child the mania returned and she died. In another case the insanity came on the fourteenth day; she was treated at home for some time, and at last was sent to an asylum, where she died in three or four weeks. While I

agree with Dr. Rohé that chloral and bromide are better than opium in most cases, there are exceptional cases where the opium is much better.

Dr. John Neff: I have had three cases of puerperal mania. The first patient was Irish; the labor normal; the puerperal period was normal up to the fifth day, when her husband came home drunk and in twenty-four hours she had developed puerperal mania. She was removed to an asylum and died in five days. The second case had eclampsia which came on before and continued twenty-four hours after labor. She developed puerperal mania, from which she recovered at home. She has since been confined and has had neither eclampsia nor insanity. The third case was treated at home without success and was afterward sent to a private asylum, where she apparently recovered. During the following five years she was well most of the time, but finally committed suicide.

Dr. T. A. Ashby: I have seen only one case of puerperal insanity and that not a violent one. There was a bad family history and she had had slight attacks before she was confined. She recovered, but has not been perfectly sound. I have had two cases after laparotomy, in which I consider sepsis to be the direct cause. In one case seven days after operation pus collected in the pelvis and she became wild and maniacal. Three weeks afterward the sepsis cleared up and she recovered. The second case occurred recently. I removed a large pus sac, which ruptured, and I used drainage. At the end of 72 hours she developed mental trouble, jumped out of bed, tore open the wound, but finally recovered without a rise of temperature above 100°. When the wound was completely healed the mental trouble disappeared.

Dr. G. Lane Taneyhill, in closing the debate, remarked that he had mentioned septicemia as a cause, but did not dwell on it in speaking of treatment, for none of his seven cases were traceable to septicemia. Four recovered, two died and one went into profound melancholy. He did not agree with the modern gynecologists that "nearly all the cases of puerperal mania are attributable to septicemia." He would even in these days administer morphia hypodermically in large doses to the raving puerperal maniac in preference to giving sulphonal or paraldehyde. He proposed and did use "mechanical restraint" in certain cases of this disease when the wild woman, after a struggle of four hours of excitement, was not bodily controlled by the nurses and continued to resist strong anodynes administered in different ways. It must be remembered his paper exclusively contemplated those cases characterized by furious delirium.

Wm. S. Gardner, M. D., Secretary.

MEDICAL PROGRESS.

Bathing in Alaska.—A correspondent to the New York *Medical Record* says that in Alaska the method of taking a bath is somewhat heroic. Every trading post has a bath-house and the people are supposed to avail themselves of its privileges once a week. A person accustomed to living in a milder climate would have a good deal of hesitancy about undressing in one of these places, as the temperature is always below zero. In an inner room an arch of stones is built so that a fire made beneath can penetrate. A trap-door in the roof answers for a chimney. After the stones have become thoroughly heated and the smoke has passed out, all the coals are removed and the trap-door closed. In this room stands a cask of warm water and another that is ice-cold. When the bather enters he pours hot water on the stones until the room is filled with steam; then, taking a seat on a bench, he waits till the perspiration streams from every pore in his body. Next he takes a bunch of dried twigs and leaves, prepared for the purpose, with which he scrubs himself till all the impurities have been removed from the skin, following this with a wash-off in warm water and soap. He concludes his bath by dashing a bucket of ice-cold water over his body and then rushing to the dressing-room, where, with his teeth chattering and shivering in every limb, he resumes his clothes.

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See also Publishers' Department, Page 78.

BALTIMORE, MAY 12, 1894.

A Hospital for Consumptives.

As noted in these columns not long ago, the need of a hospital in or near Baltimore for consumptives is becoming greater each year, and as a result of an agitation of this subject in the medical and lay press, a number of ladies and gentlemen, including members of the medical profession, met and after discussing various plans, formed committees to take steps to arouse general interest and devise means for raising money to carry out this deserving charity.

The advisory board of physicians, sanitarians and laymen will procure reports from other cities where such hospitals are in successful operation and will report at a subsequent meeting the result of these reports and will then advise as to the character of the buildings, the situation, whether in the city or in the suburbs, and the various details. All physicians in the city and State are cordially invited to attend all meetings, of which due public notice will be given, and aid by their presence and co-operation.

New York is just now formulating plans to erect a similar hospital and the renewed interest all the world over in the study and prevention of consumption makes the building of a hospital for consumptives in a medical centre like Baltimore a very needful and opportune movement. It may be that in time in connection with the hospital, a mountain home will be built and there is certainly no more suitable place than in the mountains of Western Maryland. The whole movement deserves the help of every citizen of the State of Maryland.

*

A National Bureau of Health.

ONCE more it seems necessary to arouse the profession to the importance of using every effort for the passage of a bill in Congress to form a National Bureau of Health. It is only by united effort and by constant appeal to our representatives in Congress that the end will be attained. Not only medical journals, but the lay press of all parties, has made a strong fight for the establishment of this bureau and in our commerce with other countries which protect themselves by sending us their sick and diseased, it is no more than right that we should defend this fair country against disease and pestilence from without. In addition, there are filth diseases like typhoid fever which spread and do incalculable harm and which without respect to State and municipal boundaries spread from community to community and it is for the better protection against disease both from within and from without that a bureau of health is needed. The general work of such a bureau is shown in the proposed bill which has already been printed.

"To collect and diffuse information upon matters affecting the public health, including statistics of sickness and mortality in the several States; the investigation, by experimental and other methods, of the causes and means of prevention of disease, the collection of information with regard to the prevalence of contagious and epidemic diseases both in this and other countries; the publication of the information thus obtained in a weekly bulletin, the preparation of rules and regulations for securing the best sanitary condition of vessels from foreign ports, and for the prevention of the introduction of infectious diseases into the United States and their spread from one

State into another, which rules, when approved by the President of the United States, shall have the force of law; the ascertaining of a suitable system of inspection that these rules and regulations are properly carried out and enforced; the advising and informing of the several departments of the Government and executives and health authorities of the several States on such questions as may be submitted by them to it, or whenever in the opinion of the bureau such advice and information may tend to the preservation and improvement of the public health, and in general to be the agent of the general Government in taking such action as will most effectually protect and promote the health of the people of the United States."

*

Criminal Carelessness.

THE recent outbreak of typhoid fever in a town in New Jersey was due to what is usually called "criminal carelessness." A milkman in whose family there was a case of typhoid fever washed his cans in contaminated water and then distributed infected milk to many customers in that town, with the result that several cases of the disease broke out, and not a few deaths followed. After some investigation the cause of the disease was traced to this milkman, but not until irreparable harm had been done, and even then while every one blamed the man who carelessly started the epidemic, no one suggested nor indeed is there prescribed any form of punishment for such persons. New Jersey is a model State and may be induced to enact such health laws as will mete out a just punishment to persons who carelessly or even ignorantly spread disease.

Another case of carelessness occurred in a family which alone suffered. The head of the house had a large collection of fowls in the country, and some of them had what is known as the "rupe," which corresponds to diphtheria in man. Some of these chickens found their way into the house and the youngest child, who amused himself by fondling the chickens, was taken sick with diphtheria and soon succumbed. The isolation of the child and the killing of all the diseased fowls prevented the spread of the disease. Here are two instances of criminal carelessness and there are many others on record. If some form of punishment could be inflicted to suit such cases they would not occur so often.

The International Sanitary Conference.

THE result of the work of the International Sanitary Conference recently held in Paris has just been made public, and the object of this conference to enact measures preventing the spread of infectious and contagious diseases, especially those of an epidemic form, is well known. The conference this year deals more particularly with Asiatic cholera and the endeavor is to cut off cholera at its starting place in India rather than to let it loose over the country and then to quarantine infected places.

There are two ways of stamping out cholera in the beginning; one is to ensure pure drinking water everywhere and the other is to keep the Mecca pilgrims clean. Beyond these all measures are as nothing. Hagar's well where the Mussulman pilgrims wash and drink is nothing better than sewer water, and the deaths from drinking this water are many hundreds in one day. The pilgrim has a right to die for the glory of Mohammed, but has he the right to carry this plague wherever he goes and thus to the rest of the world?

If the conference can convince the powers interested that strangling cholera at its birth is more important than the curtailing the rights of the pilgrims, then the most important point will have been obtained. The conference seems to be in earnest this year and it is likely good will come of its proceedings. The delegates for the United States are Drs. E. O. Shakespeare, Stephen Smith and Preston Bailhache.

MEDICAL ITEMS.

New York is taking steps to build a hospital for consumptives.

*

It has been proposed to establish an association for the care of convalescent children.

*

The Legislature of New York has passed a bill establishing an epileptic colony in that State.

*

Dr. John C. DaCosta has been elected president of the Philadelphia County Medical Society.

*

The prevalence of homeless cats in Brooklyn is said to contribute very largely to cases of insomnia there.

*

The Medical College of Virginia will elect a successor to Dr. M. L. James (who has resigned) as Professor of the Practice of Medicine.

Dr. W. C. Curry has been appointed vaccine physician for the Ninth ward, vice Dr. Ellis Micheau, resigned.

*

The eighth annual meeting of the American Orthopedic Association will be held in Washington from May 29 to June 1, inclusive.

*

The Medical and Surgical Staffs of the Johns Hopkins Hospital held their annual dinner at the hospital a few days ago.

*

The Medical Department of the Columbian University, Washington, D. C., held its annual commencement April 24. There were twenty-seven graduates.

*

The annual meeting of the American Medical Publishers' Association will be held at White Sulphur Springs, West Va., Friday and Saturday, August 3 and 4, 1894.

*

At a meeting held for the purpose recently in London it was proposed to erect a memorial to the late Sir Andrew Clark and also to add to a London hospital a wing to bear his name.

*

The first meeting of the Pennsylvania State Medical Examining Board will be held June 11, after the commencement of the Medical Department of the University of Pennsylvania, which takes place June 7.

*

All physicians who are interested in the establishment of a hospital for consumptives in or near Baltimore, are requested to be present at the next meeting of the organization, on Tuesday, May 15, 1894, at twelve noon, in the Y. M. C. A. building, corner Charles and Saratoga Streets.

*

The American Sanitary Association has been formed with the object of discouraging the manufacture and sale of impure and injurious foods and medicines, and to encourage the introduction of wholesome and honestly manufactured articles of food, medicine, clothing and sanitary appliances in general.

*

The liquor question is to be thoroughly investigated in its physiological, ethical and legislative aspects, by a Committee of the "Sociological Group." The committee includes representative men, among whom are Cardinal Gibbons, Dr. John S. Billings, and President D. C. Gilman, of the Johns Hopkins University.

Experts report a very defective system of ventilation in the House of Representatives at Washington. The gratings in the floor through which the pure air is supposed to come covers decaying papers and is used more as a receptacle for dirt and as a cuspidor than for ventilation, and what little air does pass into the room in this way is unfit for use.

*

The necessity for hospital accommodation for British and American visitors who may have contracted disease of an infectious character during their temporary stay on the Continent has given rise to the formation of a committee for the purpose of providing accommodation for such individuals. Accordingly an agreement has been entered into with the mayor of Cannes for the lease, with the option of purchase, of a villa named "Sunny Bank." This has been fitted up for the reception of patients of the above-named description and is now in full working order. A separate building, which experience has found to be necessary for acute cases, has been added, and the erection of an isolation block is in contemplation. The establishment may be regarded as a home or pay hospital, as first-class patients pay 12f. 50c. ($2.50) and those of the second class about half the same sum.

*

The faculty of the College of Physicians and Surgeons, Baltimore, were appointed last Wednesday. They include: Dr. Thomas Opie, dean, and Dr. Aaron Friedenwald, treasurer. Professors: Drs. T. S. Latimer, Aaron Friedenwald, C. F. Bevan, G. J. Preston, Thomas Opie and George H. Rohé. Dr. J. W. Chambers will have the chair of clinical and operative surgery; Dr. George Thomas, professor of diseases of the nose, throat and chest; Dr. J. H. Branham, professor of anatomy; Dr. C. Hampson Jones, associate professor of physiology; Dr. Harry Friedenwald, associate professor of diseases of the eye and ear; Dr. Julius Friedenwald, associate professor of pathology, and clinical professor of diseases of the stomach; Dr. F. C. Bressler, clinical professor of the diseases of the stomach; Dr. Frank Dyer Sanger, associate professor of anatomy; Dr. W. F. Smith, demonstrator of anatomy; Dr. W. S. Gardner, associate professor of gynecology; Dr. W. Wayland Frames, demonstrator of anatomy, and Dr. Edwin Geer in charge of dispensary, and chief of out-door department of the Maryland Lying-In Hospital.

Book Reviews.

A Primer of Psychology and Mental Disease. By C. B. Burr, M. D., Medical Superintendent of the Eastern Michigan Asylum, etc. Detroit: George S. Davis, 1894. Pp. vi–104. (Price, $1.00).

Like most aids, this little book is written to help the student in a very difficult branch. It is exceedingly concise but very well expressed and seems to be comprehensive. The most remarkable part of it is a glossary of the most common words which every student should have long since known by the time he is sufficiently far advanced to understand this book.

An Aid to Materia Medica. By Robert H. M. Dawbarn, M. D., Professor of Comparative Surgery and Surgical Anatomy New York Polyclinic. Third Edition, Revised and Enlarged, by Woolsey Hopkins, M. D. New York: G. P. Putnam's Sons, 1894. Pp. 131.

This is a new edition of an old book revised and brought down to date on account of the change in the Pharmacopœia of 1890. The author thinks that most physicians use a limited number of drugs in actual work and many of those learned in student life may be forgotten. He lays stress on the importance of pleasant medication and advocates the use of the metric system. Active principles and tablet triturates should replace the old bad-tasting medicines. There is nothing very new in the book. It is interleaved and printed in the usual clean style of the publishers.

Essentials of Nervous Diseases and Insanity. By John C. Shaw, Clinical Professor of Diseases of the Mind and Nervous System, Long Island Hospital Medical College, etc. Second Edition, Revised, 48 Illustrations. Pp. 194.

Essentials of Pharmacy. By L. E. Sayre, Ph. G., Professor of Pharmacy and Materia Medica of the School of Pharmacy of the University of Kansas. Second Edition. Pp. 200.

Essentials of Anatomy. By Charles B. Nancrede, Professor of Surgery and of Clinical Surgery in the University of Michigan, etc. Fifth Edition, 180 Illustrations. Pp. 388.

Essentials of Medical Physics. By Fred. J. Brockway, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. Second Edition. Pp. 330. Philadelphia: W. B. Saunders, 1894.

These four books, former editions of all of which have been noticed in these columns before, are a part of Saunders' Question Compends, and are intended for students. In the Essentials of Nervous Disease, no changes have been made except the correction of a few errors in the first edition. In the Essentials of Pharmacy the author has revised this edition to agree with the Pharmacopœia of 1890. The Essentials of Anatomy is enlarged in the fifth edition by a number of osteological plates. In the Essentials of Physics no great changes are noted. The illustrations are good and numerous. The author has drawn largely from Ganot, which he considers too bulky for the medical student. All of these books give evidence of careful work on the part of the publisher. The price is one dollar each.

Reprints, Etc., Received.

Retinitis Albuminuria. By L. Webster Fox, M. D. Reprint from *Times and Register.*

Epiphora or Watery Eye. By L. Webster Fox, M. D. Reprint from *Times and Register.*

Tait's Perineal Flap Operation. By F. Byron Robinson, B. S., M. D., Chicago. Reprint from *Chicago Medical Recorder.*

Eyesight, in Middle Life and Old Age, with a Few Hints for its Care and Preservation. By L. Webster Fox, M. D. Reprint from the *Journal of the Franklin Institute.*

Oxygen as a Distinct Remedy for Disease and a Life-Saving Agent in Extreme Cases. By A. W. Catlin, Brooklyn. Reprint from *Brooklyn Medical Journal.*

The Commoner Animal Parasites of the Skin. By A. A. Ohmann-Dumesnil, A. M., M. D., St. Louis. Reprint from the St. Louis *Medical and Surgical Journal.*

Critique of Macroscopic Examination of Specimens Removed in Thirty-two Consecutives Laparotomies, with one Death. By F. Byron Robinson, B. S., M. D., Chicago. Reprint from the *Journal of the American Medical Association.*

Tricresol or trikesol, is said by Dr. J. M. Charteris, of Glasgow, to be three times as strong as carbolic acid as a germicide and only a third as poisonous and he thinks it is not only safer than carbolic acid used externally, but suggests the possibility of giving it internally combined with an alkaline base in specific infectious diseases.

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NOTES.

WALKER'S phytoline is said to reduce weight without harm.

*

PENTAL, or trimethylethylem, is an anesthetic both safe and effective, being less dangerous than chloroform and without after-effects.

*

THE value of cascara sagrada as a purgative lies in the fact that the dose does not have to be increased and its administration is not followed by constipation.

*

BISMUTH subgallate in five grain doses in capsules or tablets, before or after meals is an excellent remedy in purely functional dyspepsia with flatulence.

*

OHMEWLEWSKI reports success with the use of chloralose in cases where chloral and sulphonal could not be used. In doses of one-half to one grain it caused sleep in about a half hour, this sleep lasting from six to twelve hours.

*

THE *Bulletin of Pharmacy* quotes Unna as recommending the following procedure for removing aniline stains from the hands: "Wash the hands in a five per cent. solution of common salt, then in a five per cent. solution of peroxide of hydrogen and then dry with a piece of linen dipped in alcohol.

READING NOTICES.

When pain is the prominent symptom, Antikamnia is a desideratum, as its province is relief of pain in any and every form. And best of all, there is no danger of morphinism, no nausea nor malaise, so common with opium and its preparations.—*Cincinnati Lancet-Clinic.*

*

Chas. Day, M. D., 79 St. Mark's Square, London, says: I have prescribed your preparation, Iodia, with very satisfactory results. Its power of arresting discharges was very manifest in a case of leucorrhœa, and another of otorrhœa. In the latter case, the result of scarlet fever in early life, the discharge had existed for many years. The patient could distinctly feel the action of the Iodia on the part, and the discharge gradually dried up.

*

I have used Peacock's Bromides in four cases of epilepsy, and it is only fair for me to state that I have had good results in each case. In three of these cases there were no attacks while the medicine was used, although they had been frequent and severe in spite of the exhibition of the ordinary bromide salts. I say while it was used because I have had difficulty in convincing some patients that they were not entirely cured after using one bottle, but where I have been able to have them continue the treatment for a reasonable time after the disappearance of the fits, there has been no return of them even after the medicine was stopped.—Chas. C. Johnson, M. D., Columbia, S. C.

*

Dr. Chas. Nedskov, Sorrento, Fla., says: Papine alone and in combination has been quite satisfactory. A case just dismissed may serve as an illustration. The patient, a married lady, I found suffering severely from ovarian congestion and neuralgia. After preliminary treatment I ordered Papine, teaspoonful doses, half-hourly administered. Pain relieved after third dose, and next day she felt, to use her own words, "a thousand times better." Combined with Bromidia, a very noted improvement was effected in the case of "nervous prostration" and inveterate chronic insomnia.

Papine's chief recommendation appears to be its uniform reliability, coupled with comparative freedom from deleterious after-effects.

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ORIGINAL ARTICLES.

EMPYEMA.

OPENING REMARKS ON THE SPECIAL SUBJECT FOR GENERAL DISCUSSION BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, AT ITS ANNUAL MEETING, APRIL 24-27, 1894.

By Charles W. Mitchell, A. M., M. D.,

Lecturer on Pathology and Clinical Medicine, University of Maryland.

THE achievements of modern antiseptic surgery have greatly lessened the scope of the physician's work. Within recent years he has, perhaps too readily, turned over to the surgeon's knife cases which he formerly regarded as peculiarly his own.

Appendicitis, pyosalpinx, empyema, are in recent medical literature regarded as strictly surgical affections, with which the physician has little or nothing to do. Great harm, however, is done by drawing too fixed a boundary line between medicine and surgery. It divides responsibility; it separates common interests; it makes the physician dread the knife, the surgeon more eager to use it. Worse than all, it prevents the careful and continuous study of disease from its inception to its end.

It is with the purpose of pointing out the duties of the medical man in the treatment of empyema that this paper is written; and in so doing it will be necessary to discuss briefly the occurrence, etiology and diagnosis of the disease.

Empyema occurs much more frequently than is generally believed; especially is this true in children. The tendency to the disease is most strongly marked during the first five years of life. Many deaths attributed to the common infectious diseases of childhood are in reality due to the complicating purulent pleurisy. In all febrile affections of children careful and frequent physical examination of the chest is necessary to avoid errors in diagnosis. Cassel has recently reported a case of bilateral empyema in an infant thirteen weeks old. So, too, in adults post-mortem examination will often show that the symptoms referred to the persistence of a pneumonia, purulent infiltration, etc., are entirely dependent upon pus in the chest. This truth should raise a suspicion of empyema in every case of pneumonia when the dullness on percussion does not promptly clear up.

Empyema occurs as a primary and as a secondary affection. The exudation may be purulent from the outset or a serous collection may gradually become converted into pus. One case is reported where, five days after the beginning of the symptoms, a large quantity of pus was evacuated from the chest. It is, however, the secondary cases that are

of the greatest importance from the standpoint of this discussion, because they are so generally overlooked.

Empyema may be said to occur in the course of any infectious disease, even those which ordinarily do not affect the lung. Many recent cases have been reported following influenza without the intercurrence of a pneumonia. Especially is it apt to occur as a result of a terminal infection in the course of any of the long list of chronic diseases which ordinarily give rise to simple sero-fibrinous exudations in the pleural cavity. It is not so liable to occur after a simple hydrothorax, but when a true lesion of the pleura, however old, exists, an invasion into the body in any way of the pyogenic organisms is quite likely to produce pus formation in the chest cavity. This is in accordance with the well-known pathological law that healthy serous membranes resist bacterial invasion, but whenever the peritoneum and pleura have been injured they tender a hospitable reception to the invading bacteria, and as a result of mixed infection, empyema and purulent peritonitis frequently occur.

No antecedent disease of the lung is essential to the occurrence of purulent pleurisy, and it is a great mistake to overlook its possibility, because especial attention has not been drawn to respiratory symptoms. Among the diseases other than those of the lung, to which empyema may be secondary, are to be mentioned all the exanthemata, diphtheria, typhoid fever, influenza, cerebro-spinal meningitis, and infections with the bacillus coli communis, amœba coli, proteus vulgaris, etc. Vertebral and costal necroses, of course, frequently produce it.

In ordinary cases the diagnosis can be made with little difficulty. Among the symptoms and signs which characterize a purulent rather than a sero-fibrinous exudation in the chest cavity may be mentioned greater height and more irregular course of the temperature, the occurrence of successive chills or rigors, greater rapidity in the pouring out of the fluid, persistence of the fever for more than two weeks, Baccelli's sign, which depends upon the fact that the whispered voice-sounds are transmitted more readily through a serous than through a purulent fluid. Œdema of the chest may occur in empyema. But not only must empyema be differentiated from simple pleurisy; it must also be diagnosticated from other conditions. The pulsating forms must be distinguished from intra-thoracic aneurism. And in cases when the pus has burrowed through the chest wall (empyema necessitatis) the condition may be mistaken for abscess from bone necrosis. In young children, owing to the persistence of bronchial breathing and to the signs dependent upon a coincident bronchitis, there is great danger of empyema being mistaken for acute pulmonary phthisis; especially is this error apt to be made in empyema following the acute infectious diseases. In such cases it is well to remember that in empyema in early life there is apt to occur a prominent bulging forward of the first and second intercostal spaces. Rivet has produced this sign experimentally. In cases in which rupture into a bronchus occurs, abscess of the liver must be eliminated.

But all these methods of diagnosis may still leave us in doubt. Sometimes fever is altogether absent. Henoch reports a series of such cases. Baccelli's sign may fail us. There may be no œdema of the chest wall. There is but one certain method of diagnosis and this consists in the introduction of the exploring needle. This should be done not once, but several times if need be, in all cases of pleurisy when the febrile symptoms continue more than two weeks, and whenever one side of the chest becomes more than half full. One cannot insist too strongly upon the utmost care in the disinfection of the skin and the instruments used.

In my early hospital experience I have more than once witnessed with successive acts of aspiration the gradual transformation of a clear limpid serum to foul, putrid pus. Not only is the careful introduction of the needle attended by no risk, but it renders the diagnosis certain and at the same time the pus, if examined bacteriologically, will often

give valuable information with reference to the prognosis.

The difficulties sometimes met with in withdrawing the pus through the exploring needle are too well known to require much comment, but I believe that the vast majority of failures to obtain pus when it is really present are due to the use of too small a needle and to its too slow introduction, which causes the pleura to be pushed in front of it instead of being penetrated.

Whenever possible (and it certainly is possible for all of us practicing in large cities) the pus obtained should be examined bacteriologically, because the subsequent treatment of the case will depend upon the character of the infecting organisms.

The pus obtained may be sterile. This is generally regarded as indicating a tuberculous origin. There are many exceptions to this rule. The most frequently found organism is the diplococcus pneumoniæ; especially is this true in children, and this, along with the greater elasticity of the chest wall in early life, explains the relative ease with which children recover after empyema.

If, however, the pus contains staphylococci or streptococci, early and more radical treatment is indicated because these organisms are so much more tenacious of life and more infectious than the pneumococcus. The streptococcus makes the prognosis very grave, as there is great danger of general septicemia. In cases dependent upon the bacillus coli communis and proteus vulgaris the prognosis is also bad.

It must not be thought, however, that the variety of infecting organisms furnishes the only clue to the prognosis. The general symptoms must be regarded. I believe that great importance must be attached to the natural elasticity of the chest wall of the patient affected. Other things being equal, the greater the original expansive power of the chest wall the better the outlook. This is the reason that rachitic children with weakened and deformed thoracic walls, and old subjects of emphysema with their lessened elasticity, stand pleural inflammations so badly.

From what has already been said it will be apparent that the chief duty of the physician will be in the direction of prophylaxis. I believe that a large number of cases of pus formation in pleurisy can be prevented. We should remember that just so long as a serous fluid remains in the pleura is there danger of secondary infection with the pus organisms.

Our treatment of every pleurisy, then, should be prompt. We should strap the chest on the affected side and keep all the secretions in good order. We may try the dry diet if the patient will submit to it. We should give sodium salicylate freely. After absorption has begun we can often hasten it by systematic massage and frictions of the chest wall. I believe that fly blisters and the administration of tincture of the chloride of iron often hasten absorption in cases of moderate severity.

If the symptoms persist for more than two weeks, or if at any time the fluid occupies more than half of one side, aspiration should be done at once. The operation may be repeated several times if necessary. If the use of the exploring needle reveals pus and the pneumococcus is present, we may hope that aspiration alone may effect a cure if the patient is a child or a young adult with very elastic thoracic walls. Even in these cases, however, if the aspiration is not followed by a prompt disappearance of all the fluid, it is useless to repeat the operation and the case must be referred to the surgeon. The presence in the chest of a collection of inspissated pus, even though it be due to the comparatively benign pneumococcus, is a constant menace to the individual. Acute tuberculosis may be lighted up at any time. Generally speaking, in cases due to other infections aspiration alone is absolutely worthless.

Here it becomes the duty of the physician to emphasize to the patient and his family the necessity of surgical interference. Then for a time the patient passes out from under the medical man's control, but if he does not die, he generally comes back. In other words, it becomes the physician's duty to do

what the Germans call "completing the cure." Many of the surgeon's most brilliant results are only made possible by the faithful, intelligent, persevering after-treatment of the family doctor, who directs the patient as to diet, habits, exercise, etc. So, too, after the surgical treatment of empyema we, as physicians, fall short of our duty if we fail to guard our patients against the dangers which constantly threaten those who have been the subjects of purulent pleurisy. There is the great danger of tuberculosis. The injury done to the lung and pleura renders the patient more susceptible to respiratory diseases of all kinds. We must keep our patient well. My public and private experience has led me to believe that a large number of cases of lateral curvature of the spine are entirely due to neglect of simple measures after pleural inflammations.

After recovery from the radical operation the patient should undergo a course of pulmonary gymnastics. He should swing Indian clubs and dumb bells, employing such movements as directly increase the expansion of the chest, and practice deep breathing in the open air several minutes every day.

Even immediately after the operation great benefit can be derived from the method of expanding the lung proposed by Dr. Walter B. James, which is now so widely employed in hospitals. The patient should wear flannel all the year round, should receive prompt treatment of all coughs and colds and should be made, if possible, to follow an outdoor life. In short, he should be treated as one who is predisposed to tuberculosis. We should always remember that the pleura is the seat of an old lesion and therefore so much more liable to infections of all kinds. There are many points of interest which I trust will be dwelt upon in the discussion. I have aimed to make this paper suggestive rather than exhaustive.

937 Madison Avenue.

ASEPSIS IN MINOR PROCEDURES.

Read Before the Medical and Chirurgical Faculty of Maryland, April 27, 1894.

By Hunter Robb, M. D.,
Associate in Gynecology, Johns Hopkins University.

The progress of the science of bacteriology has been retarded quite as much by the zealousness of well-meaning but ignorant supporters, as by the attacks of its bitterest and most scientific foes, and the same may be said for the doctrine of asepsis. I am quite convinced that no surgeon should lay upon his fellows "burdens grievous to be borne" unless he can guarantee some practical results to repay them for their trouble. But when it has been proved, for instance, that a single stitch which has been used in closing a wound without having been properly sterilized has caused the death of the patient, we must all agree that there is no such thing as a trivial detail in the carrying out of an aseptic technique.

I propose, therefore, to-day to speak of the principles of asepsis as applied to certain minor procedures.

In the clinical thermometer and the hypodermic syringe we have two very useful instruments if they are properly employed. I question whether it was ever our habit to put into the mouth of a patient a thermometer that had not been first cleaned, but all of us, I am sure, have taken our hypodermic syringe from its case, dissolved a tablet in water, filled the syringe and plunged it without hesitation into the subcutaneous tissue. Of course our needle was apparently clean, but was it always surgically clean? One cannot deny that thousands of such punctures have been made without any bad results, but in our profession and with our present knowledge we are justified in allowing the patient to incur no risk which can be avoided by any foresight or trouble on our part.

In every work on surgery a certain amount of space is devoted to remarks

on the subject of hypodermic injections. We are told what site should be chosen, and what possible dangers are to be avoided. Such suggestions are generally carefully noted and acted upon; but while much stress has been laid upon the dangers of puncturing a vein, or injuring the periosteum, and the like, the risk of setting up an infectious process, if the puncture be not made aseptically, has not by many authors been thought worthy of mention. That the danger of sepsis is by no means hypothetical is evidenced by the large number of cases of hypodermic punctures which have been followed by abscess formation or localized phlegmons, and we have only to refer to the recent monograph of Fraenkel, of Hamburg, on "Gas Phlegmons," in which he reports two cases of fatal, spreading gangrene following such punctures, to further illustrate the danger which lurks beneath this ordinarily simple operation. Cases are on record in which erysipelas, malignant pustule and tuberculosis have actually been transmitted through the medium of the hypodermic syringe. The sources of infection to be particularly remembered are as follows:

1. The fluids to be injected.
2. The syringe and its needle.
3. The skin of the patient.
4. The hands of the operator.

Although the dangers of an infection from the two last named sources are not very great, yet, unless the case is very urgent, the careful surgeon will take time to disinfect both his own hands and the skin of his patient before introducing a hypodermic needle. Fortunately solutions of drugs, such as quinine, antipyrine, apomorphine, sometimes used for hypodermic injections, possess a certain amount of antiseptic power which tends to prevent the development and multiplication of pyogenic bacteria in them. On the other hand, solutions of the drugs in most common use, such as atropine, morphine, cocaine, and ergotine, favor the development of bacteria, and when kept too long or if made without proper precautions, are frequently found to be swarming with micro-organisms, with the result that not only are their medicinal properties sometimes impaired, but thousands of bacteria may be placed in the subcutaneous tissues. Though the greater number of these organisms may be harmless, occasionally pyogenic bacteria will be present which may give rise to the formation of local abscesses which are likely to prove very troublesome and even dangerous to life.

Fluids used for hypodermic injections must be sterile, and it would be better to make up a fresh solution each time. In private practice where the tablets are so much used, a very simple expedient enables us to make a practically sterile solution in a few minutes. A dessertspoonful of water is held over a lamp until the water boils. The tablet being then allowed to roll from its phial into the spoon is immediately dissolved and we have a practically sterile solution. Of course where the drug is one which is injured by a temperature of 100° C. the best we can do is to have the water boiled and allowed to cool somewhat before the tablet is placed in it. Where solutions must be kept for some days if they have been prepared aseptically, the addition of from two to three drops of pure carbolic acid for every 30 c. c. (one ounce) of the solution will prevent the development of bacteria and will not be sufficient to do any injury. Cocaine may be dissolved in various menstrua, but keeps best in a 1 to 10,000 solution of corrosive sublimate.

The sterilization of hypodermic syringes has been and is still a difficult problem. The complexity of the instrument, and especially the inaccessibility of the piston, renders it by no means an easy task to free it from germs. The ingenious syringe of Koch has no piston and is easily sterilized, but it is too inconvenient for practical use, and the many improvements have as yet failed to give us a satisfactory instrument. Before using the ordinary syringe the piston should be withdrawn from the barrel and both placed in a 5 per cent. solution of carbolic acid for ten minutes, which will render them sterile. Sterile water is afterwards drawn through the syringe to get rid of the carbolic acid. Hypo-

dermic needles made of platinum can be rendered perfectly sterile by heating them in the flame of a Bunsen burner or of an alcohol lamp, but exposure of the ordinary needles to the flame soon ruins them.

Exploratory punctures and paracentesis are not so frequently resorted to as in former days, since major operations have been so much simplified, but it is still occasionally necessary to draw off the fluid from the abdomen in ascites or other conditions either for purposes of diagnosis or for the relief of the patient. The needle, trocar, or rubber tubes used should be sterilized by being boiled in a 1 per cent. soda solution, and the skin of the patient, as well as the hands of the operator, should be rendered clean.

All of us have too often seen cases of cystitis in the male caused by the introduction of a dirty catheter into the bladder. The rubber or metallic catheters may be easily rendered sterile by being boiled for five minutes in a 1 per cent. soda solution. The best we can do with the gum-elastic catheters is to soak them in a 1 to 1000 bichloride solution for at least an hour, and wash them off in hot sterile water just before using them. Catheterization of the female bladder is a simple procedure, but when done improperly has often been responsible for a setting up of a serious cystitis or even a fatal suppuration in the kidney or their pelves. The normal urine is probably always sterile, bacteria being discharged through the kidney only when there are lesions in the renal parenchyma. In the majority of cases of infection of the urinary passages the pathogenic bacteria have gained entrance from below. It is interesting to note that one of the most frequent organisms which is found accompanying cystitis, pyelitis and pyelonephritis, is a bacterium which cannot by our laboratory methods be distinguished from the bacillus coli communis. The staphylococcus pyogenes aureus, streptococcus pyogenes and proteus vulgaris are also sometimes found in cases of cystitis.

These facts should teach us the importance of thoroughly cleansing the external parts before we undertake the catheterization of the bladder. The patient should be in the dorsal position with the knees somewhat separated, the sheet being thrown over them, leaving the vulva exposed. We were formerly taught that a physician who was unable to catheterize a patient without exposure was unworthy to continue the practice of medicine. This maxim with our knowledge at that time was true enough, since a knowledge of anatomy and an educated touch are always of the greatest importance. But bacteriology has taught us that "catheterization in the dark" is no longer justifiable. The labia ought to be held apart with a gauze sponge and the meatus urinarius and the parts around it are to be thoroughly cleansed with sponges of cotton and warm boric acid solution before the catheter is inserted. One great difficulty in the way of aseptic catheterization of the male has lain in the impossibility of sterilizing the gum-elastic catheters which are still often used, without at the same time injuring them. Fortunately in the female this difficulty has been obviated by the introduction of the glass catheter, which is easily rendered sterile by being cleansed with soap and warm water and then soaked in a 1 to 500 aqueous solution of bichloride of mercury. If by chance a glass catheter is not available one of rubber or silver may be employed after having been sterilized by being boiled in the 1 per cent. soda solution for five minutes. For a lubricant sterilized oil or, better, glycerin, may be used. With the glass catheter no lubricant is necessary.

It has been suggested that the urethra should be washed out carefully with some sterile fluid, inasmuch as this takes away a certain number of bacteria, but in the case of the female it has been shown that the chances of contamination from the urethra in the absence of a definite urethritis are very slight. After being used, the catheter should be scrubbed with brush and soap, and hot water or soda solution should be syringed through it until the lumen is thoroughly clean. It should always be kept in a 1 to 500 solution of corrosive sublimate

or a 5 per cent. carbolic acid solution until it is needed again.

Irrigation of the bladder is often indicated, and for this purpose sterilized solutions of boric acid with or without glycerine or normal salt solution are generally used. The warm solution is filtered into a sterilized rubber bag or fountain syringe, the end of the conduit tube from the bag being attached to the sterilized glass catheter. After the urine has been drawn off, the solution is allowed to run slowly into the bladder, the stream being controlled by a pinchcock placed on the tube. After about a pint has run in, or sooner if the patient complains of pain, the tube is disconnected from the end of the catheter and the bladder allowed to empty itself. The process may be repeated two or three times until the washings are clear.

The observance of such precautions will, I am sure, minimize the number of the so-called accidents which still too frequently occur. Without these measures ninety-nine cases out of a hundred may do perfectly well, but it is our bounden duty to use every endeavor to attain to certainty and to eliminate from medicine, wherever we can, the element of guess-work which is still the bane of our profession.

OPERATION FOR AN OLD DISLOCATION.

Read Before the Surgical Section of the College of Physicians of Philadelphia, March 9, 1894.

By John B. Roberts, M. D.,
Of Philadelphia, Pa.

The patient had an old dislocation of the elbow, which occurred two years ago, and was the result of a fall from a carriage, which was overturned. The injury was evidently a backward dislocation of both bones of the forearm, with compound fracture of the radius at the junction of the upper and middle third. The injury occurred two years before the patient, who is exhibited, came under my care at the Woman's Hospital. She at that time had the right arm rigidly extended, with no motion at the elbow; suffered with pain and numbness in the fingers at the ulnar side of the hand, due to pressure on the ulnar nerve, and had a suppurating sinus at the point of depression, shown in this cast made of the arm before operation.

It seemed to me that it was proper to attempt to treat the old dislocation, although of two years' standing, by making a resection in order to get the arm in a flexed position. I cut down upon the olecranon, and found that the head of the radius and the olecranon were soldered by callus, to the humerus, in the abnormal position. The ulnar nerve was displaced and in a condition of tension. I was compelled to chisel loose the radius and ulna and cut off the triceps tendon in order to put the bones at the elbow in the position of flexion, which would be so much more useful and convenient, even if the elbow were immovable. In order to unite the triceps tendon to the ulna after flexing the joint, I was obliged to lengthen it by cutting a V-shaped flap out of the tendon. This I did with its apex upward, and then turned the flap over with its point downward, and sutured it to the stump which had been left attached to the olecranon. I used silk sutures. I lessened the tension on the ulnar nerve by replacing it; in the course of a few days the numbness of the fingers disappeared.

In order to cover in the gape in the skin, I made a large plastic operation by dissecting a flap from the forearm. Her arm was now flexed at a right angle, and in the course of, perhaps, two months, I got a considerable degree of motion. The radius and ulna were still united at the seat of the sinus by a bridge of callus, which prevented pronation and supi-

nation. I therefore determined to cut down and chisel out of the bridge of bone and see if I could establish pronation and supination. Upon cutting down I found a sequestrum due to necrosis of the radius at the point of fracture. I chiseled away a considerable amount of bone and took out the dead portion of the radius. Knowing that the head of the radius would not be likely to rotate, as it had no cartilage upon it, I determined to make an artificial joint in order to get some pronation and supination in addition to the amount of flexion already obtained at the elbow. I excised three-quarters of an inch of the radius, and then encouraged the girl, after I had removed the portion of bone and the wound had partly healed, to make motions of rotation of the hand.

She obtained a certain amount of *passive* supination and pronation, and the fingers became more flexible. During our endeavors at making passive extension and flexion of the elbow, fracture of the ulna took place, some weeks later, in the upper third of the shaft. This necessitated putting her arm in a splint and prevented our continuing with the massage and other motions to get motion at the elbow and wrist. As the elbow would probably become stiff, I, in order to get the hand more toward the face, allowed the fragments to unite with a little angularity. You see now a bend or angular deformity at the seat of fracture, which enables her to bring the hand nearer the mouth than otherwise would have been possible. The wound has not entirely healed. She lost nearly all the flexion and extension she had from the first operation during immobilization of the joint for repair of the fracture of the ulna. She has a little motion at the elbow, not enough to be useful; there is practically no supination or pronation of the hand, but the numbness of the fingers is gone, and she can bend her fingers, which were very stiff, pretty well. She has, and had, good motion at the wrist. We have not gained a great deal, therefore, except the right-angle position of the elbow, motion of the fingers, and freedom from pain and numbness. If fracture had not taken place I think we would have obtained considerable motion at the elbow and have been able to maintain the false joint at the point of radial resection so as to give her some rotation of the hand.

The case is interesting to me because of the lengthening of the tendon of the triceps, the attempt to establish a point of motion in the shaft of the radius, when the head is adherent by ankylosis to the humerus, and the ease with which bridges of callus uniting the radius and ulna can be removed.

SOCIETY REPORTS.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND.

NINETY-SIXTH ANNUAL SESSION, HELD AT THE HALL OF THE FACULTY, BALTIMORE, APRIL 24 TO 27, 1894.

Dr. George H. Rohé, President, in the chair; Drs. G. Lane Taneyhill and Robert T. Wilson, Secretaries.

The ninety-sixth annual session of the Medical and Chirurgical Faculty of Maryland was called to order at the Hall of the Faculty, corner St. Paul and Saratoga Streets, April 24, at 12.30 o'clock P. M. After the reading of the minutes of the last meeting by the Secretary, Dr. George H. Rohé delivered the President's Address on the subject of THE EXTINCTION OF TUBERCULOSIS. (See page 19.) At the conclusion the speaker was applauded, a vote of thanks was passed, and the address was requested for publication.

Dr. A. Friedenwald then read a paper entitled, REMARKS ON THE DIFFERENTIATION OF PARALYSIS OF THE EYE MUSCLES OF CENTRAL AND PERIPHERAL ORIGIN.

Dr. J. W. Humrichouse, of Hagerstown, read a paper on CASES SHOWING THE RELATION OF VARIOUS DISABILITIES TO ABNORMAL REFRACTION OF THE EYES, WITH COMMENT UPON THEIR TREATMENT.

Dr. Hiram Woods said it was not easy to add much to such exhaustive papers

as these. He thought it was very timely to consider the paralysis of the eye muscle more especially in reference to a certain form of partial paralysis or paresis, which has an important bearing. This is the day of tenotomy, and we often get excellent results in this way when there is defective enervation or an abnormally strong muscle. There are several important points touched on in this paper, and one is the total correction of myopia. He had had a similar case and was also forced to take it to Dr. Webster, of New York, who set him straight. He had operated on the case for muscle trouble, and as he got no better he took him to Dr. Webster. He had 5½ dioptries vision in one eye, and 2 dioptries in the other.

Dr. Herbert Harlan related a case in connection with Dr. Friedenwald's paper of a woman who could move her eye only up and down, and from her statement it was evidently congenital. The superior and inferior recti were all right, but the others were not. Dr. Humrichouse's cases were successful, but not difficult.

Dr. E. J. Bernstein was much interested in Dr. Friedenwald's paper. In the correction of high myopia most men are correcting it where no pathological lesion is found, that is, where there is no lesion of the choroid. A woman came to his office with a myopia of 18 degrees; it was not a conical cornea but the curvature was very great.

Dr. A. Friedenwald said the subject was a great one, and he only wanted to differentiate between central and peripheral lesions.

Dr. W. M. Nihiser then read a report of a case of CHRONIC INFLAMMATION OF THE MIDDLE EAR, TERMINATING IN CEREBRAL ABSCESS AND DEATH.

Dr. Charles W. Mitchell then opened the special subject for general discussion by a CONSIDERATION OF THE TREATMENT OF EMPYEMA FROM A MEDICAL STANDPOINT. (See page 79.)

Dr. L. McLane Tiffany, from a surgical point of view, said that Dr. Mitchell had made the diagnosis and cured the patient, and he could only suggest operative measures. He considered it as a collection of pus within a serous sac, not having forfeited its serous character and not having become a sac of granulation. The prognosis will vary with the length of time the empyema has existed and the character of the pus. A recent case in the young will justify a favorable prognosis, also in the middle-aged, but in the old, more die. On the other hand, when it has existed for some time and the serous membrane has lost its serous character, the prognosis in the middle-aged will be grave; in the young there will be scoliosis and a sinking in of the chest walls. The treatment is to do nothing or something and the question is, Shall it be allowed to burst, shall it be aspirated or shall an incision be made and the pus evacuated? Spontaneous evacuation does not occur often unless it is a case of secondary infection. Generally speaking, it occurs late in the existence of the trouble, and usually below the second or third rib in front two or three inches from the sternum, that being the point of selection where there is the greatest tension. The surgeon is not supposed to allow such a perforation to take place, but it will not interfere with another opening in another place. Aspiration has been followed by recovery in children. The recovery may be expected when the pus contains a pure culture of the pneumococcus, but when it contains the organisms of the surgical diseases, the recovery is not so certain. The point of suppuration is usually at the point of dullness. The chest is to be opened where it is dull and this is usually towards the base, and the base of an empyema varies because of the change in the shape of the sac. The lungs expand and the diaphragm is raised and the seventh axillary space in the intercostal space in the post-axillary line is to be chosen. The fluid will drain well if the patient sits up, lies down or is on the side. This is to be done even should there be a spontaneous opening of the chest wall in front. An empyema does not drain from a spontaneous opening in front. The chest may be opened between the ribs or a piece of the rib or

ribs may be taken out. The latter is generally needless, but very exceptionally it is necessary. This is seen in shrinking in of the normal chest. There is space enough between the ribs to make an incision or to put in a tube. It will not be pressed upon. If a falling in of the chest walls is to be expected and the ribs come together, then an excision of the ribs is necessary, but only costectomy; it does no good and no harm, but it is not necessary. An incision at the upper border of the rib is quite sufficient to allow a drainage tube to enter. Use free drainage of an empyema and keep the lumen of the tube patent. Costectomy is simple; take a piece of the rib out first, scrape the peritoneum off and take a piece of the rib out for two or three inches and let the tube remain in the pleura. The vessels and intercostal nerves all lie near the lower surface of the rib; therefore the incision is made close to the upper border of the rib. An intra-mural abscess is sometimes met with in empyema and it means perforation of the chest walls; it will be found below the nipple in front. In such a case if opened, a probe will not pass into the chest wall. Where there is an empyema or continuous fever, an abscess in the front part of the chest will be found to have occurred. He operated on an empyema in the summer and in the following spring the patient had typhoid fever with an intra-mural abscess and he supposed it was due to reinfection. As for the treatment of the patient after the operation, he found it generally inexpedient to wash out the chest. It is only necessary where there is sepsis and even then he had rarely done it. He never does it at first. If the patient is not too old and it is a simple empyema, the tube may be removed in about two weeks. The open tube in the opening causes a change in the pus. As regards prognosis, a recent case in a young person will generally heal with no deformity, while an old case in an older person is apt to leave a deformity. Estländer's operation is a good one and is done when there is much falling in. There is generally little trouble in the healing of the lower part of the chest. Let the incision point down and the cavity will stay open whatever is done.

Dr. Robert W. Johnson said there was very little left for him to say. This operation is a very old one and it is not a product of the last ten, twenty or hundred years, but it is discussed by Cicero in speaking of Prometheus. Hippocrates had a clearer idea of it than the masters of the middle ages. He spoke of the different ways the operation was performed. He thought the aspirator was important in making a diagnosis, but it will not cure. The fluid should be withdrawn gradually to relieve tension, but the relief of tension must not be too sudden, for the vessels must have time to become accustomed to the new condition of things. The drainage tube is a good thing and deserves mention as a great discovery. Washing out the cavity was not so important as the substance used. The bichloride solution, carbolic acid, permanganate of potash, were not good. The tube will fall out when the time for its removal comes.

Dr. Randolph Winslow thought an empyema was an abscess under peculiar circumstances. The diagnosis has been made and now the pus must be evacuated; if not it may be absorbed; this is not frequent, but it is not so uncommon, especially in children. After opening the abscess, remove the pus and put in a drainage tube and try in every way to establish free drainage. Dr. Tiffany objects to resection of the ribs; he thinks the thorax should be opened at a point where the best drainage can be secured, which is at about the posterior angle of the scapula and towards the axilla; in that place an opening will drain in any position. Remove the periosteum from the ribs and take out sections of one or two ribs; it is an advantage to do this, because it gives better drainage. Still it is quite possible that cases recover without this. Yet it is better, for the ribs pinch the tube and they themselves become necrosed from pressure and if removed it does not add to the gravity of the operation and it does add to the efficiency of drainage. It is no advantage to irrigate the cavity, not even once; the patient is weak and it adds to

his discomfort and danger. The connection with the bronchi may cause danger. Use no strong agents in washing out the cavity. It is generally better not to wash out unless with exceptions, as in high fever, etc. Introduce drainage tubes, not one, but two side by side, attached to the skin or with safety pins. Or fill the opening with iodoform gauze. The pus should not be evacuated too rapidly, for collapse will occur, and if it is gradual, air will enter as the pus comes out, and the pressure is equalized. When the lung has been compressed a long time it will not expand rapidly, and sometimes not at all. If it does not expand the ribs sink in and we have a cavity with chronic suppuration and for this the resection of a certain number of ribs is necessary. The length of time a tube should remain in the chest is not an arbitrary matter. When the discharge ceases to be free and purulent it is time to take the tube out or it may be pushed out by the granulations. After an operation the wound should be dressed antiseptically and redressed as often as necessary.

Dr. F. C. Bressler, in connection with this subject, showed a child about five years old, which was supposed to have peritonitis; he examined it and made out an empyema on both sides, which is comparatively rare. He operated and after it seemed to be well there was pain in the abdomen and pus was seen to be oozing from the umbilicus. He did a partial laparotomy and found a pus channel right and left under the peritoneum.

Dr. J. W. Chambers thought that aspirating was only useful from a diagnostic standpoint. The opening should not be made too low down, as the diaphragm will press upwards and push out the tube and make it appear as if the opening had healed up when it had not. He did not believe it made any difference how rapidly the pus was let out. The danger of this was exaggerated just as is the danger of giving chloroform. The drainage tube should be allowed to remain as long as there is anything to drain.

Dr. I. E. Atkinson regretted that he had not come in in time to hear Dr. Mitchell's paper, but he could not help taking exception to what Dr. Chambers said about letting out the pus. In a recent case the pus is let out much more freely than in a case of long standing. The lung is temporarily compressed in recent cases and will expand at once. He has drawn off as much as 80 ounces in a recent case of hydrothorax, but he would not dare to do it in an old case. The lung is collapsed and cannot expand fast enough and the chest wall cannot retract and there is danger of fatal syncope. Many writers recommend that not more than 20 ounces be drawn off at one time. He thinks the same thing holds in an empyema.

Dr. John N. Mackenzie should like to have heard more of the discussion on excision of the rib. While we all admire that difficult piece of surgery, he had often thought that rib excision was not necessary and he was glad to hear that Dr. Tiffany was of the same opinion.

Dr. S. K. Merrick referred to a case in which the danger of letting out the fluid too rapidly was exemplified, as fainting took place and the patient was greatly shocked.

Dr. J. M. T. Finney mentioned one point which had not been touched. He was treating an empyema following pneumonia at the Johns Hopkins Hospital. The case was operated on and the cavity was irrigated, which was his practice at that time. During the second or third day the man had an alarming convulsion for an hour. The next day he was irrigated and the convulsion was repeated and it was still more alarming. The case baffled the surgical side and Dr. Osler, of the medical side, was called in and made a diagnosis of pleural epilepsy as reported by Charcot. It is a very rare disease. The irrigation was stopped and the patient recovered. He has seen no cases of pleural epilepsy since that time. He thinks that those not irrigated do better. He believes in exsecting the rib if necessary and agrees with Dr. Chambers about the removal of the drainage tube. In reply to Dr. Rohé he said the man had never had epilepsy before this attack.

Dr. F. C. Bressler said that not much had been said on the treatment of empyema in children. In draining the pleural cavity of children the difference must be noticed. In adults the pleural cavity must be drained by exsection of the ribs, and from one-half to two-thirds of the pleuritic lesions under five years, rib exsection should not be done except in some cases where there is not good drainage with elevated temperature; only wash out the pleural cavity of those cases of fetid smelling openings of the cavity. In the case mentioned he operated and let four to five days intervene between the two operations. He left the tube in and on each day he cut off a little piece. It is not a good surgical procedure to aspirate the chest; the more it is done the more it has to be done.

Dr. Charles W. Mitchell said that one danger overlooked by the opponents of aspiration: it has broken through into the bronchus and passed out that way. He does not believe that air gets into the pleural cavity from the bronchus. There is only oozing; there is no direct connection. He does not agree with Dr. Bressler on aspiration in children.

MEDICAL PROGRESS.

GROWING PAINS.—Parents have for a long time handed down to succeeding generations the tradition that pains in the limbs of a growing child are a necessary evil and not associated with any one disease, and physicians have generally encouraged this theory; but Dr. P. B. Bennie, in the *Archives of Pediatrics*, has completely ignored this idea and argues that all pains in growing children are due to some specific cause, such as myalgia from fatigue, rheumatism, disease of the joints, fevers, adenitis, etc., in which rapid growth is only a concomitant and not a causal constituent. He says in conclusion: "This malady, 'growing pains,' with its frequent concomitant, growing fever, like its congener, disorders of dentition, vanishing from the realm of pathology through that of fancy, is fast sinking into oblivion in the medical literature of the past. As a separate morbid entity it exists now principally as an article of faith. The complaint still maintains, however, a strong hold of the lay mind and forms an extremely common lay diagnosis which is often the cause of much suffering and even death through leading to the neglect of curative measures at a time when they are most effective. But the day is approaching when its grip will be loosened, for the history of medical superstitions shows that they begin to wane first among the thinkers in the profession, and finally disappear among the uneducated laity and "growing pains" will be found to be no exception to the rule."

* * *

AN ASEPTIC DRAINAGE TUBE.—There has long been a desire to find the best means of draining the abdominal cavity after operations. With the exception of Miculicz's method by iodoform, or sublimate gauze, which is convenient and porous, the glass tube still seems to be preferred by most operators, although it does become clogged. In general it is considered better to remove the fluids while they are clean and thus avoid sepsis. Dr. T. A. Ashby, of Baltimore, is a strong advocate of drainage. During the past year Dr. Joel W. Hyde (*Brooklyn Medical Journal*) has devised a new drainage tube, which he describes as follows: "This drainage tube consists of a double glass canula, curved to fit the wound and the locality of the operation. It has four eyelet holes on either side for any pus or exudate to enter. It has a continuous and uniform calibre throughout its course, through which the sterilized and absorbent wicking is drawn, several inches at necessary intervals, thus pumping out all deleterious matter and keeping the wound dry and clean.

"The wicking is boiled for two hours in water, then dried and placed in ether. It is then put in a hot biniodide solution, or it may be sterilized after boiling in water, by an ether and iodoform mixture. It is then dried between layers of aseptic cheese-cloth and wound on spools, which are also equally protected. The spools are placed in aseptic boxes, with a rubber tube attachment to each,

through which the aseptic wicking is conveyed to the drainage tube. This connecting tube is about fifteen inches long, to allow the spool to lie by the side of the patient in bed. A double fold of iodoform gauze can be used in place of a rubber tubing to protect the wicking."

Experiments made with water, thin starch fluid and blood serum all show that these wicks will in a short time absorb and drain away all the fluid. The advantages which Dr. Hyde claims for this drainage tube are that—

1. It is narrower than the usual tube, and it conforms to the line of incision.
2. It is impossible for the tissues to clog the openings and thus defeat its intended purpose.
3. It forms a complete pump, which removes all pus, blood or serum.
4. It is absolutely aseptic.
5. It can be safely entrusted to any intelligent nurse without danger to the patient.
6. The surgeon can always know what is going on at the bottom of the wound.
7. It is very light and strong.
8. There is no danger of fecal fistulæ resulting from its use.

* * *

Surgery of the Gall Bladder.—Dr. A. W. Mayo Robson, in the *British Medical Journal*, shows that where medical means have failed in disease of the gall bladder, surgery holds out a good chance of success. He emphasizes that with due skill and adequate care operations on the gall bladder and bile ducts are among the most successful of the major operations, but as many of them are extremely difficult, and as it is impossible to say beforehand whether any case may not prove so, he thinks such surgical work should be undertaken only by those who have had experience in abdominal surgery, and who have witnessed or helped in several operations of this kind. As soon as this is the case we shall cease to witness the varying rates of mortality in the hands of different operators, of from 50 to almost 0 per cent., and shall probably find that, excluding cases of malignant disease associated with jaundice, the all-around mortality will not exceed 5 per cent. He hopes the time is not far distant when it will be fully recognized that though cholelithiasis, so far as its causes and its early treatment are concerned, is distinctly a condition for medical treatment, it is both unjust to the patient and unfair to the profession to continue medical treatment until serious complications supervene, or the patient is almost, if not quite, past relief, before the aid of surgery is invoked.

* * *

Peroxide of Hydrogen in Stomatitis.—Boennecken, in a translation from the *Deutsche Medicinische Wochenschrift* in the *University Medical Magazine*, calls attention to the importance of disinfecting the mouth during febrile and wasting diseases. He believes that the solutions of potassium chlorate and potassium permanganate, generally employed, are not sufficiently strong to be antiseptic, especially when the contact is short, and that strong solutions are too painful. He speaks very favorably of peroxide of hydrogen, which is non-toxic, free from irritant properties, and is an efficient antiseptic in solutions as weak as 2 per cent. or even less. He states that it destroys fetor in a few minutes, and that its continuous use is followed by a decided improvement in the condition of the mucous membrane of the mouth in twenty-four hours.

In the discussion which followed the reading of the paper, Leo stated that he had also obtained good results with the drug, but that in chronic cases solutions stronger than 2 per cent. acted more favorably. Walters spoke highly of peroxide of hydrogen in 5 to 10 per cent. solutions in mercurial stomatitis. Bing regarded potassium chlorate as equally effective as peroxide of hydrogen.

* * *

Topical Treatment in Laryngeal Phthisis.—In the Section on Laryngology at the Congress at Rome, as reported in the *Lancet*, Mr. Lennox Browne, F. R. C. S., Edin., made a joint communication with Dr. D. Heryng (Warsaw) and Dr. Goughenheim (Paris) on this sub-

ject. They presume that most laryngeal lesions in the course of a pulmonary tuberculosis are tuberculous, and that others may be primarily so. Topical treatment they hold to be indicated, though rarely curative, because of its great value in allaying symptoms. In some cases the process of disease might be arrested. The indications to be considered are: (1) The stage of disease in the larynx; and (2) the stage of disease in the lungs. For hyperemia, anemia, and infiltration menthol, iodol, and aristol are employed, and for ulceration and hyperplasia the curette and the application of lactic acid. Punctures and incisions are not advocated, or the extirpation of the arytenoid cartilages. Their personal experience is adverse to tracheotomy. Concurrent measures of hygiene, internal remedies, and suitability of climatic surroundings are essential adjuvants to success.

* * *

Electricity in Gynecology.—The rise and fall of electro-therapeutics in the treatment of some diseases of women has been very rapid in the past few years, but some of its firm supporters, as Apostoli and Massey, still have faith and use it probably more than others. The former, Apostoli, presented a paper on this subject at the Medical Congress at Rome and the *Lancet* gives an abstract of it as follows:

Intra-uterine electro-therapeutics (faradic, galvanic, or sinusoid) steadily and patiently applied deserves to be placed at the head of conservative gynecological therapeutics. 1. Because it most frequently induces a symptomatic amelioration which often gives place to cure. It is of chief value in endometritis and the principal functional troubles (amenorrhea, dysmenorrhea, or metrorrhagia); it is very efficacious in non-cystic fibroma; very useful (but not always) in non-suppurative peri-uterine inflammation; powerless alone in cystic collections of all kinds and suppurative lesions of the pelvic organs and appendages. 2. Because, in those cases in which it is inefficacious, it allows us to use its very impotence (by an attentive study of its harmless operative and post-operative reactions) for clearing up or confirming diagnostic doubts, thus hastening a surgical interference which has previously been postponed or even refused. 3. Because, if the immediate symptomatic consequences of its application are in general favorable, the remote results are not of less interest—*e. g.*, the subsequent occurrence of pregnancy. Sixty-seven women treated by Dr. Apostoli entirely by intra-uterine applications of electricity have had after a variable period, but most often towards the end of treatment, one or several consecutive pregnancies, which bear witness to the efficacy of the treatment. 4. Thus gynecological electro-therapeutics, far from showing itself hostile to surgery, to which it seeks, on the contrary, to point the road and to assure the legitimacy of its indications, claims its own place, it may be in a great number of cases to avoid a dangerous and useless mutilation, or in some others to authorize surgical interference, or, finally, in certain diseases to finish the work of the surgeon, who has exhausted his efforts, and to bring about in a more efficacious and prompt manner complete symptomatic and functional recovery.

* * *

Treatment of Burns.—A saturated solution of picric acid applied on gauze compresses is the latest treatment for burns, as recommended by Dr. P. Filleul, of the Charité Hospital, of Paris. The cloths are soaked in the solution, wrung out dry and left on for a long time until they dry on the burn. It does not irritate the skin nor is there danger of poisoning; but the great disadvantage is that every thing that comes in contact with the picric acid is turned yellow.

* * *

Dowe's Shot-Proof Cloth.—Dowe's shot-proof cloth as a means of protection to the soldiers in war was recently exhibited at one of the meetings of the Surgical Congress at Berlin. Gun cartridges fired at short range failed to penetrate this cloth and caused no shock to the wearer of the clothes. The German Government will probably use this cloth to protect the bodies of the soldiers. It will

cause a decrease in the amount of emergency surgery on the battle field.

* * *

Novel Treatment of Fracture.—Cases of delayed bony union have long since been treated in this country by cutting down on the seat of fracture and wiring or screwing the broken parts together. Now, Mr. Arbuthnot Lane (*British Medical Journal*) advocates in these days of bold, antiseptic surgery to cut down on every oblique fracture of the leg, expose the fragments, bring them into accurate apposition, drill holes and fasten by steel screws. He says there is immediate relief of pain by this method, absence of tension and discomfort due to extravasation of blood into the tissues and shortening of the period of treatment. He asserts that this is especially to be recommended in the laboring man, to whom time is money. He does not tell us what becomes of the steel screws.

* * *

A New Method of Giving Creosote.—Ever since the discovery of creosote it has been given for lung diseases, and particularly for tuberculosis, with varying results; and later the more refined guaiacol has taken its place. Dr. Reynold W. Wilcox after a long experience has gone back to creosote as possessing more value in these troubles than guaiacol. He has used it in solutions, in inhalations as recommended by Flint and Beverly Robinson, in soluble capsules with cod liver oil, which he rejected on account of the nauseous eructations.

Of late, however, he has begun the use of the carbonate of creosote, which consists of beechwood creosote (ninety-two per cent.) in chemical combination with carbonic acid (eight per cent.), which forms a clear, pale, almost colorless liquid of syrupy consistency, becoming thinner by heat. It can be administered hypodermically, if it first be warmed, through a large needle or in an emulsion with the yolk of an egg and water and flavored with an aromatic syrup, or in gelatine capsules containing ten or twenty minims each.

In this way the creosote is eliminated by the breath. It may cause the urine to be dark, but otherwise it produces no irritation of the stomach, no malaise nor diarrhea. Fifteen to twenty drops per day for a child, and one to two or even as much as four drachms for adults will be the proper dose.

* * *

The Anti-Toxic Function of the Liver.—It has been already established that the liver possesses a power of retaining certain poisonous alkaloids in high proportion and in their most active state—that is, when injected into the circulation and not merely absorbed by the mouth. Explanations have been hazarded as to this protective power of the liver against these toxic agents, and quite recently Dr. Schupfer, working under Professor Colasanti, Lecturer on Physiological and Clinical Chemistry in the University of Rome, has contributed elaborately to the solution of the question. His experiments, as mentioned in the *Lancet*, were made on frogs—animals which tolerate removal of the liver well, and keep alive for days after the operation, nay, in some cases for weeks. The alkaloids were injected into frogs in their normal condition and into those which had been operated on, and every care was practiced to watch the phenomena resulting. The alkaloids used were cocaine, atropine, apomorphine and pilocarpine. Dr. Schupfer embodies his conclusions in a memoir read before the Academia Medica di Roma, and they are to the following effect: The liver, by its sole intrinsic action due to the specific activity of its cellules, can diminish the toxic power of the alkaloids with which it is brought into contact. Such action is manifested not only in the case of poisons introduced through various channels into the organism, but also in the case of poisons elaborated internally within the organism itself in consequence of putrefactions or of products due to the activity of the tissues. From this he deduces a practical lesson—that, namely, of having recourse to internal disinfections and to a special alimentation, so as to obviate or minimize "auto-toxication" in all those maladies in which the liver does not perform its functions normally.

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See also Publishers' Department, Page 98.

BALTIMORE, MAY 19, 1894.

Palpation of the Vermiform Appendix.

THE abdomen is now so freely and fearlessly opened by surgeons for diagnostic purposes, that Dr. George M. Edebohls (*American Journal of the Medical Sciences*) makes a strong plea for the use of palpation, especially in diagnosing disease of the vermiform appendix. He stands on the right of the patient, who, with thighs slightly flexed, lies on the back. The operator begins at the umbilicus and gently, but firmly and deeply, presses on the various organs from the umbilicus to the right anterior superior iliac spine. He uses as a guide the right common and external iliac arteries. The appendix is usually found almost immediately outside of these vessels. The variable location of the appendix and its common deep situation behind the cecum are not real difficulties and are easily overcome.

Dr. Edebohls believes that the origin of the appendix is practically always found at what is known as McBurney's point, and in his experience he has never yet seen a case in which the full cecum concealed it. It needs but a fair, unprejudiced trial of this method of palpation of the vermiform appendix, in his opinion, to be convinced of its value, and unless the thickened appendix and limited tenderness can be recognized by palpation, the surgeon will not be justified in operating. The value of abdominal palpation is not sufficiently appreciated by the too eager operator, and the desire to use the knife causes many a good surgeon to pass over the minor details of the diagnosis. Dr. Edebohl's method of palpation is worthy of emulation, not only of the appendix, but of all the abdominal organs.

*

The Discussion on Empyema.

THE innovation at the last meeting of the Medical and Chirurgical Faculty of the selection of a special subject to be opened by one member and discussed by physicians and surgeons, formed a very interesting and instructive feature of that meeting. The opinions on the treatment of empyema from a medical and surgical standpoint and in the young, middle-aged and old, were varied and each speaker was undoubtedly arguing from his own experience. The conclusion of the discussion seemed to show that good results might be obtained in various ways and that the best depended more on the guiding hand than on the method.

The differences of opinion were principally as to the manner of withdrawing the fluid from the chest, whether rib exsection was necessary and as to the general prognosis. The physicians relied largely on partial and slow aspiration, taking care to avoid the complication of syncope and collapse which are liable to follow the too sudden withdrawal of a large quantity of fluid from a long compressed lung.

The surgeons differed as to whether costestomy should be done or not, some arguing that free drainage should be procured at any cost, and others that there was room in the intercostal space for free drainage. The expressions, too, were varied on cavity washing. Such discussions bring out the stronger side of a society and certainly awaken research and investigation.

THE fact that a few cases of small-pox have appeared in Baltimore need not terrify the soul of any one, for the efficient work of the Health Commissioner and vaccine physicians have already cut off further spread of the disease, but the question now arises whether it is not the duty of all physicians to advise their patients and families under their charge to be vaccinated. There is always some risk of acquiring the disease, and vaccination is so simple and involves so little, while an attack of small-pox would mean a great deal to any thus afflicted.

Small-Pox in Baltimore.

It is probably the simplicity of vaccination that causes many persons to hesitate; indeed the question is daily asked: "Doctor, do I need to be vaccinated?" It is now ten or twelve years since the last time small-pox appeared to any extent in this region and it stands to reason that all born since that time need this protection and many who were vaccinated at that time need revaccination. Yet in spite of this some physicians are telling their patients that vaccination is not necessary at present.

The constant and close intermingling of sick and well, poor and rich, in churches, theatres, street cars and other places, affords ample opportunity for the spread of disease and why should small-pox prove an exception? Therefore vaccinate with reliable virus all who have never been vaccinated and any who have not been vaccinated since 1883 and their protection will be assured.

* * *

THE Legislature of New York has passed and the Governor has signed the bill establishing a Colony for Epileptics in that State. The bill provides for the purchase of a tract of 1875 acres of land in the Genesee valley. The law requires that all the buildings shall be put up on the cottage plan. A board of five managers is provided for and Dr. Peterson has been appointed chairman; also a woman has been appointed to look after the women and children. In addition, a lawyer, a Homœopathic physician and an editor were added to the board—a remarkable collection. The managers may accept bequests and it is thought that many wealthy persons will leave money to the colony and build cottages. A medical superintendent, steward, matron, pathologist, nurses, school-teachers, teachers of various arts and industries, are to be appointed as needed. The colony will probably number from fifteen hundred to two thousand when full, but it will not be ready to receive patients for more than a year. It is sure to be self-supporting in time if it is kept free from politics, and may eventually rival the famous colony at Bielefeld in Germany. Dr. Frederick Peterson is president of the Board and Mr. George M. Shull, of Mount Morris, N. Y., is secretary.

* * *

THE person who knows how to rest properly and give up entirely to relaxation is the one who will accomplish most when at work. The busy physician works hard, as do men in other occupations, all the winter and earns a period of rest in the summer, and yet how many men stay on in the same old rut throughout the warm months, laboring under the hot sun with the false idea that they are gaining on those that do rest. Every man needs the relaxation that complete change of scene and absence from toil alone can bring. One of the best ways to attain this is by a sea voyage; whether to Europe or elsewhere is a matter of no import so that a week or two of ship life be spent. On board ship no message can come, no telegrams or letters are received. Physicians should rest while they take a holiday and return renewed for the winter work.

* * *

AT the recent meeting of the State Society, a committee was appointed to revise the physicians' fee table. It will be interesting to know who will use this fee table, revised or not. The man with the alley practice has little use for a fee table, while the specialist, whose fee is supposed to be written in several figures, is glad to forget such a disagreeable thing as a scale of charges prepared by the society to which he has sworn allegiance. Physicians are accused of charging what they can get; they certainly often do not get what they deserve. It is not easy to see whom the fee table, revised or unrevised, will benefit.

* * *

THE Food Inspection Bill has become a law. It will come under the supervision of the Health Office, and will demand the appointment of an analytical chemist and several inspectors.

MEDICAL ITEMS.

Chicago had 544 cases of small-pox reported in April and 162 cases the first week in May.

*

Michigan, Illinois and New York are all forming plans to build hospitals for consumptives in their respective States.

*

Dr. Charles Gilbert Chaddock is associated with Dr. I. N. Love as editor of the *Medical Mirror* of St. Louis.

*

Mrs. D. Hayes Agnew has given $25,000 to the University Hospital of the University of Pennsylvania, in honor of her late husband.

*

Dr. E. L. Keyes is said to have received $60,000 for his services in attending Mr. Vanderbilt on his four months' cruise on the *Valiant.*

*

Commencing with the July issue the *Archives of Pediatrics* will be edited by Dillon Brown, M. D., Adjunct Professor of Pediatrics at the New York Polyclinic.

*

St. Louis is said to be building a hospital exclusively for colored people. Baltimore is also about to open a hospital and medical college for colored people.

*

Dr. N. E. B. Iglehart has been appointed resident physician at Chattolanee Springs and Dr. William Pawson Chunn resident physician at Buena Vista for the summer.

*

Dr. J. F. Winn, of Richmond, Virginia, has been transferred from the Professorship of Diseases of the Nervous System, to be made Clinical Professor and Demonstrator of Obstetrics in the Richmond University College of Medicine.

*

The Garrett Sanitarium for Children at Mt. Airy, Md., will open for the summer on Wednesday, June 6. It is a hospital for children of poor parents, who are sick, or in need of surgical treatment. It is not a "home" for children who need only a change of air. The Garrett Dispensary for Children will remain open in the city as usual at 27 N. Carey Street, except Sunday and Wednesday of each week; on the latter day the physician in charge visits the Sanitarium at Mt. Airy. The Resident this year will be Dr. T. B. Futcher. His three immediate predecessors, Drs. L. F. Barker, O. G. Ramsay and H. C. Parsons, are all at present Assistants in the Johns Hopkins Hospital. Dr. Walter B. Platt is the Physician in Charge of the Garrett hospitals at Mt. Airy and in Baltimore.

*

The following appointments have been made in the University of Maryland and University Hospital: Dean, Dr. J. Edwin Michael; Treasurer, Dr. Randolph Winslow; Demonstrator of Anatomy, Dr. J. Holmes Smith; Assistant Demonstrator of Anatomy, Dr. A. H. Mann, Jr.; Anatomical Assistants, Drs. E. Van Ness, E. R. Owings, T. Cooke, Jr., John Turner; Demonstrator of Physiology, Dr. T. W. Clark; Demonstrator of Obstetrics, Dr. K. B. Batchelor; Demonstrator of Ophthalmology, Dr. Frank M. Chisolm; Demonstrator of Surgery, Dr. W. B. Platt.

Dr. Chas W. Mitchell has resigned his position as Lecturer on Pathological Anatomy, and has been elected to the position of Lecturer on Clinical Medicine in the University Hospital. Dr. St. Clair Spruill, whose administration as Medical Superintendent of the University Hospital has been so successful, will continue in that position; and Miss Janet Hale, Superintendent of the Training-School for Nurses connected with the University Hospital, will also continue her successful work in that position. Drs. H. C. Utley and H. H. Arthur have been appointed Resident Physicians to the Free Lying-In Hospital. Dr. Frederick Carruthers will continue to represent the University of Maryland in the capacity of Resident Physician to Bayview Hospital, with Dr. R. M. Johnson, of the recent graduating class, as his assistant. The vacancy in the visiting staff to Bayview Hospital, produced by the death of Dr. Wm. J. Jones, was filled by the election of Dr. Thaddeus W. Clark to that position. Dr. B. B. Lanier has been elected Dispensary Physician, *vice* Dr. H. B. Thomas, resigned. Dr. H. O. Reik has been appointed Chief of Clinic to the Eye and Ear Department, *vice* Dr. J. W. Funck, resigned.

The new laboratory building has been pushed with great energy and will be completed and fully equipped by the middle of the summer, by which time also all damage to the old University building by the fire of December 2, 1893, will have been repaired. The prospects of the School for the coming session are very gratifying.

Book Reviews.

A Manual of Therapeutics. By A. A. Stevens, M. D., Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania; Demonstrator of Pathology in the Woman's Medical College, Philadelphia, etc., etc. Small 8vo., pp. 435. Price, $2.25. Philadelphia: W. B. Saunders, 1894.

This book differs little from similar compends except perhaps that it is slightly better than most. The drugs are arranged alphabetically and not according to physiological action, as is usually done. The definitions are short and clear and frequent presciptions illustrate the use of the drug. The sections on applied therapeutics and on incompatibilities are good and will be appreciated by the student.

The Physician's Bed-Side Record and Dietary. By Gideon C. Segur, M. D., Hartford, Conn. The Plimpton Manufacturing Company, 1894. Price, ten cents each, one dollar per dozen.

This is a very convenient little book for recording pulse, temperature, respiration, etc., and also a place for diet directions for the nurse, and accompanying it is a list of well-tried recipes for various light, nourishing foods and cooling drinks. This is a subject to which the average physician has given too little attention, and the use of such a book with explicit directions for nourishment should be insisted on in every case.

Lectures on Auto-Intoxication in Disease, or Self-Poisoning of the Individual. By Ch. Bouchard, Professor of Pathology and Therapeutics, etc., Paris. Translated, with a Preface by Thomas Oliver, M. A., M. D., F. R. C. P., Professor of Physiology, University of Durham, etc. Philadelphia: The F. A. Davis Co., 1894. Pp. xvi-302. Price, $1.75.

This volume is extremely modern in its ideas and while written from the standpoint of an enthusiastic Frenchman it is very accurate and the translator has done his part of the work more than well. It is by no means what is called a practical book, but it will be read by the advanced student and studious physician with much pleasure and profit. The subject of auto-intoxication is an exceedingly interesting one, which has rarely been so thoroughly treated in one volume before. The author advocates general antiseptic treatment which he thinks will be adopted in the future.

Gonorrhea. Being the Translation of Blennorrhea of the Sexual Organs and its Complications. By Dr. Ernest Finger, Docent at the University of Vienna. Third Revised and Enlarged Edition. With Seven Full page Plates in Colors and Thirty-six Wood Engravings in the Text. New York: William Wood & Company, 1894. Pp. vii–324. Price, $3.

The first edition of this translation appeared several years ago in Wood's Medical and Surgical Monographs, but the present work has been much enlarged and improved. Since the first edition the author has studied the gonococcus and its manner of growth, and has also made anatomical studies of chronic urethritis. A not uninteresting part of the whole is the historical references, which are usually so lacking in medical works. Occasional typographical errors are noticed.

Reprints, Etc., Received.

Report of the Jefferson Medical College and Hospital, 1893.

The New Orleans Sewerage System. Reprint from the New Orleans *Times-Democrat*, 1894.

Tenth Biennial Report of the State Board of Health of Maryland for the Two Years ending December 31, 1893. Annapolis, 1894.

A Case of Double Vagina, with Operation. By Hunter Robb, M. D., Baltimore. Reprint from the *Johns Hopkins Hospital Bulletin*, 1894.

Abstract of Two Articles Treating of Progress in Midwifery. By Hunter Robb, M. D., Baltimore. Reprint from *Maryland Medical Journal.*

Transactions of the American Orthopedic Association. Seventh Session, held at St. Louis, Mo., September 19, 20 and 21, 1893. Volume VI.

Three Illustrative Cases of Abdominal Section. By Augustus Schrachner, M. D., Ph. G., Louisville. Reprint from the *American Journal of Obstetrics*, 1894.

A Series of Wools for the Ready Detection of "Color Blindness." By Charles A. Oliver, Philadelphia. Reprint from American Ophthalmological Society Transactions, 1893.

The Relation of the Patellar Tendon-Reflex to some of the Ocular Reflexes found in General Paralysis of the Insane. By Charles A. Oliver, M. D. Reprint from American Ophthalmological Society Transactions, 1893.

Clinical History of a Case of Spindle-celled Sarcoma of the Choroid, with a Study of the Microscopic Condition of the Growth. By Charles A. Oliver, M. D. Reprint from Proceedings American Ophthalmological Society, 1893.

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NOTES.

A PROMINENT actress attributes her success in part to the daily use of Listerine as a gargle.

*

THE purest form of subgallate of bismuth is dermatol, which has no odor, and does not irritate or poison and is an excellent antiseptic, astringent and anti-fermentative.

*

IN typhoid fever the addition of a half-tablespoonful of hydrozone to each glass of water not only makes a pleasant and grateful drink, but has decided germicidal properties.

*

DR. ALBERT ROBIN, of Paris, has had great success with glycero-phosphates of calcium, sodium and potassium in doses of 25 centigrames (four grains) hypodermically in nervous depression, neurasthenia and allied troubles.

*

DR. ROBERT B. MORISON removes freckles with the following mixture :

Corrosive sublimate,	7 grains.
Tincture of Camphor,	4 drachms.
Rose Water,	5 "

Distilled water enough to make 6 ounces.

Three or four thicknesses of linen are moistened with this solution and placed over the freckles at night. The face is washed next day. In a few days the face becomes red and the epidermis peals off and the freckles disappear.

READING NOTICES.

Celerina and Aletris Cordial, equal parts, teaspoonful every four hours, is a most efficient remedy for amenorrhea.

*

Ox-gall, one grain of the inspissated, with one drop of oil of wintergreen to one teaspoonful of Celerina, will relieve headache. The remedy may be repeated every hour.

*

Alcoholic Excess.—N. H. Pierce, M. D., 43 Pontiac Street, Ann Arbor, Michigan, says: I have used Celerina as indicated, and am much pleased with the result. I prescribed it in a case of extreme nervous debility, bordering on tremens, through alcoholic excess, and it not only quieted the nervous excitement, but seems to have acted as an antidote to alcoholism, so that the patient, a young man, son of a widow, whose chief fault seems to have been a periodical craving for drink, has remained sober and industrious for many weeks. He was seldom sober more than a week at a time previous to this. I consider it one of the most valuable of medicines also for dyspepsia, headache, dysmenorrhea, hysteria, etc.

*

IN threatened epidemics of small-pox, vaccine virus of all kinds is foisted on the public. There is a great scope for dishonest methods in preparing and sending out vaccine points or quills. There are many good kinds of virus on the market and one that has of late been used very successfully in Vermont, in the city of St. Louis, and elsewhere, is that made by the National Vaccine Company, whose offices are in Washington. The farm is situated near Bethesda Park, Montgomery County, Maryland. An opportunity was lately given to a party of physicians and sanitarians to examine most thoroughly this model farm and the methods of preparing the ivory points. While sterilization methods cannot as a matter of course be used without detriment to the matter, the utmost precautions are taken and the most scrupulous cleanliness observed. Especial care is taken that hand contact with the virus at any stage is absolutely avoided and the animals, of which a large number is used at the farm, are treated in the best manner and are well fed and watered. The proprietors are always happy to have physicians and others interested to call at the farm or at their office in Washington.

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ORIGINAL ARTICLES.

PARALYSIS OF THE EYE MUSCLES OF CENTRAL AND PERIPHERAL ORIGIN.

READ AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 24–27, 1894.

By A. Friedenwald, M. D.,

Professor of Diseases of the Eye and Ear, College of Physicians and Surgeons, Baltimore.

IT is very important, in cases of paralysis of the eye-muscles, to be able to determine whether such paralysis is due to causes affecting parts situated within the intra-cranial space, or whether it has occurred in consequence of disease that has involved a nerve or nerves outside of that space. In the latter instance we are only concerned about the visual disturbances that necessarily are established, and with the probabilities of the restoration of the motility of the paralyzed muscle or muscles; besides these important considerations, we are confronted in the former case by conditions that may be of more or less serious omen to the most important organ in the body. In certain cases, the symptoms in either condition are so outspoken that the question whether the seat of disease is within or without the intracranial space can readily be answered ; in others, such decisions can only be safely reached after a most careful investigation of the symptoms and in not a few the evidence furnished will not be sufficient to guide us in locating the lesion.

As has already been indicated, central lesions will be classed in this paper as those within the intracranial space, and peripheral lesions as those to be looked for in parts outside of that cavity. In many modern treatises on this subject a different classification is adopted. Paralyses arising from disease at the base of the brain are added to the schedule of peripheral lesions ; and the term central paralysis is limited to those cases due to lesions within any part of the brain substance. Again a classification has been adopted by which the peripheral account has still further been enlarged by being made to include lesions affecting nerve tracts in their course from the nuclei to where they emerge from the brain (fascicular), placing nuclear paralysis as an independent variety, and restricting the term central paralysis to changes in the ultimate centres in the cortex. Interesting as these modern classifications may be from an anatomical pathological point of view the earlier conception will, in a clinical aspect, serve a better purpose.

In differentiating between central and peripheral lesions as causes of paralyses of the eye muscles, much is to be learned from the fact that but a single muscle has suffered; or if a number be involved,

their respective grouping may serve as a reliable guide. Mauthner has named the condition in which all of the muscles of the eyeball, including those within the organ, are paralyzed, ophthalmoplegia totalis. When only the external muscles are affected, and the pupillary sphincter and ciliary muscle remain intact he terms it ophthalmoplegia exterior. When only the last named muscles, however, *i. e.*, the interior muscles, are affected, he describes the case as ophthalmoplegia interior. We shall see further on that these varied conditions and attending circumstances will enable us to decide whether the lesion be peripheral, or if central, whether it be basilar or of nuclear character.

Peripheral Paralyses.—In studying this variety of our cases we must take into account paralyses of the spincter pupillae and of the accommodation which have either been induced by the local effect of atropine, or have followed trauma. When atropine is the cause of the mydriasis we have a maximum degree of pupillary dilatation which is not reached in any other condition except in glaucoma, and in the latter instance there will be sufficient symptoms to reveal the true nature of the dilatation. A trauma that is capable of paralyzing the sphincter pupillae is not apt to be overlooked. Paralysis of the eye muscles depending upon diseased conditions having their seat in the orbital cavity, as a rule, do not affect one muscle alone, but usually implicate a number of muscles, and may strike all the muscles of the eyeball (ophthalmoplegia totalis), and even not spare the levator palpebræ, adding ptosis to the picture. In these cases the eyeball will generally be protruded, and there will be pain in the orbital region. If some of the movements of the eyeball are retained, pain is occasioned on their being called into play, while pressure upon the eyeball will commonly also be painful. Sometimes the eyeball can be pushed back; more often, however, the resistance offered by encroachments in the orbital cavity, or by the pain caused by the manipulation, will defeat such an attempt.

The motor oculi, trochlear and abducens which supply all the eye muscles, enter the orbit through the superior orbital fissure in quite close company, and therefore a periostitis, etc., in that region must embrace a number of nerves in their passage. Tumors in the orbit may be the cause of a peripheral paralysis, in which case besides the marked exophthalmus produced, the eyeball is generally not protruded in a direct line forward, but pushed to one side, according to the form and situation of the tumor; in these cases the tumor can often be recognized by palpation. When an orbital paralysis is due to inflammatory conditions of the orbital tissues or to hemorrhage, the redness of the parts and the ecchymosis usually furnish adequate data for the diagnosis. Exophthalmus, which forms so prominent a feature in orbital paralysis, may accompany ocular paralyses due to central lesions. Here the normal resiliency of the orbital tissues, relieved of the resistance of the muscles, permits an advance of the eyeball. The exophthalmus, however, in the latter instance, is never of that degree which marks decided forms depending on orbital disease.

Clear as the diagnosis is in most cases of orbital paralysis, it also happens in consequence of circumscribed inflammations, small hemorrhages, and in the very beginning of tumors, that the real seat of the disease may for a time be overlooked. A variety of ocular paralyses may arise from orbital diseases in which only the inferior oblique and the muscles of the inner eye are concerned. Inasmuch as the inferior oblique acts only in association with the superior rectus in the upward movement of the eye, and as no very apparent deformity reveals itself to a casual observation, from the inferior oblique being left out in that act, the dilatation of the pupil and paralysis of the accommodation in these cases might mislead to the conclusion that such a paralysis rests upon a central lesion. Such a conclusion would be justified by the general rule that ophthalmoplegia interior, with the other eye muscles remaining intact, is not ascribable to orbital disease. We shall find a satisfactory explanation of this condition

by following the course of the respective nerves. The motor, sensory and sympathetic nerves entering the inner eye first pass through the ciliary ganglion, which lies deep in the orbital cavity. The motor fibres are derived from the branch to the inferior oblique, from which a branch is provided for the sphincter pupillae and ciliary muscle. That the lesion in a given case is not of central origin, but is due to changes affecting the ciliary ganglion, is determined by the accompanying diplopia in the upward movement, in which the image of the affected eye presents the characteristic tilting, and especially by the anesthesia which must be present at the same time. Bilateral paralyses from orbital disease may occur, especially in cases due to syphilis.

Central Paralysis.—In the consideration of central paralysis our examination carries us over an extended field. The lesion in these cases may be located anywhere at the base of the brain through which the ocular nerves pursue their course—in the cortical centres, in the nuclei on the floor of the fourth ventricle, in the nerve fibre between these points, and in the course of the nerves from their respective nuclei to their exit from the brain.

Basilar Paralysis.—When a single nerve is paralyzed by disease at the base of the brain it is exceedingly difficult to distinguish it from a like paralysis due to either lesion in the orbit or substance of the brain. Should the motor oculi be the one affected from disease at the base, the whole trunk would be acted on, consequently all the muscles supplied by that nerve governing the movements of the eye, as well as the pupillary sphincter and the accommodation, would be paralyzed. This would present a condition which could not be referred to a nuclear lesion; for in the latter instance, when the external muscles suffer the inner ones are exempt, or *vice versa*, when the inner muscles are paralyzed and the external are intact. In regard to orbital paralyses we found that it was very rare to have a single muscle paralyzed. The same rule seems to obtain with regard to basilar paralyses. I quote Jacobson, who says in this regard, "Concerning central paralysis (by which he means cerebral lesions) it is to be said that until now, neither a central isolated paralysis of the abducens or of the oculo-motor has been observed; and that only one case of paralysis of the fourth nerve due to tumor of the pineal gland has been reported. There is, therefore, good ground for assuming, in paralysis of a single muscle which cannot be traced to an orbital lesion, that it is due to a change at the base of the brain.

We have, however, a more certain means of recognizing the basilar origin of ocular paralysis and in locating the lesion in certain parts of the base when a whole group of nerves are either simultaneously or successively affected. A case in which paralysis of the motor-oculi, trigeminal, facial and olfactory nerves enter would positively indicate that the seat of the lesion is situated at the base of the brain. Equally certain would the association with trigeminal paralysis point to its origin at the base of the brain when this condition has been preceded by neuralgia of that nerve, for the latter symptom is never present in cerebral lesions.

Ocular paralyses, accompanied by loss of vision of one eye, while the vision of the other remains intact, and where no ophthalmoscopic changes present themselves, may be charged to basilar disease, and at the same time the injury to the optic nerve would have to be located at a part of the nerve anterior to the chiasm. Should a lesion at the base of the brain, causing ocular paralyses, involve the optic nerve at the same time at a point behind the chiasm, a visual disturbance would affect both eyes in the form of homonymous hemiopia. If the paralysis appears in combination with temporal hemiopia, the diagnosis is doubly sure, for while homonymous hemiopia may be due to conditions situated as high up as the cortex, temporal hemiopia must rest in disease situated in the chiasm.

Paralyses affecting both eyes in varied combinations may develop out of basilar disease. Complete paralysis of both third nerves is most likely to be due to

lesions situated at the base of the brain at the point where these nerves lie in close proximity to each other, viz.: between the crura cerebri running from the pons. In association with the paralysis of the three ocular muscles paralysis of the olfactory nerve would not only establish a basilar origin, but would also place the disease in the anterior fossa, while similar conditions, complicated with optic nerve affections, would locate the disease in the middle fossa; and paralyses of abducens, trochlear, facial, acustic, glossopharyngeal, vagus, accessory, hypoglossus, would have to originate in the posterior fossa. Leber reports a curious case of bilateral paralysis of the abducens from pressure by the carotid arteries.

Nuclear Paralysis.—In studying the symptomatology of ocular paralyses of nuclear origin the picture of ophthalmoplegia exterior assumes a conspicuous importance. Here we find that while the motor oculi and perhaps the abducens and trochlear are paralyzed, the pupil and accommodation remain unaffected. The explanation for the independence of the exterior and interior muscles in pathological processes, trespassing on the territory of the nuclei on the floor of the fourth ventricle, is to be found in the anatomical arrangement which places the nuclei of the pupil and ciliary muscle farther forward and in a distinct vascular area. There cannot therefore be the slightest difficulty in distinguishing a lesion of a nerve trunk from a nuclear lesion when the muscles of the inner eye remain exempt in a more or less extensive paralysis of the outer muscles, for when the nerve trunk of the motor oculi suffers, both the inner and outer muscles are paralyzed. It may occasionally happen that a degenerative process may be limited to the nuclei of the inner muscles and the outer muscles remain free, which condition would equally certain establish its nuclear origin.

Most cases of ophthalmoplegia have their origin in disease of the grey substance of the nuclei, and are in character similar to that upon which bulbar paralysis depends, in which the motor nuclei of the facial, glosso-pharyngeal and hypoglossal are involved. Indeed, cases have been observed in which, upon the background of a bulbar paralysis, the picture of an ophthalmoplegia has been engrafted.

While it has been satisfactorily established that in a large majority of cases of degeneration of nerve nuclei, syphilis is to be charged as the prime factor, it must be borne in mind that many other causes of varying character may enter in the play, viz.: diphtheria, influenza, tabes, disseminated sclerosis, traumatism, etc.

It is well known that paralyses of single muscles are frequently met with in the initiatory stage of tabes dorsalis, and somewhat less often in multiple sclerosis. Such cases depend upon disease of the grey matter of the nuclei, and usually are of short duration; although they may continue, or, having disappeared, recur after a shorter or longer interval.

The nuclei of the abducens and facial nerves are in such proximity that disease occurring in that region is apt to involve both nerves. In cases, therefore, when paralyses of muscles supplied by these nerves present themselves there can be no doubt as to their nuclear character.

An interesting disturbance results in disease of associated nuclear centres, termed conjugate paralyses. In such a case, for example, in directing the patient to follow an object from left to right, the eyes fail to pass the median line. While such a condition would make it appear that actual paralyses were present, we will find that in bringing an object towards the eye there is no inability to converge the visual axes.

Fascicular Paralysis.—In paralysis of central origin, in which the symptoms do not indicate either a basilar or a nuclear lesion, the damage may have been inflicted upon the nerve roots in their course from the nuclei to the base of the brain. Under certain conditions, for example, when such roots have been injured in a situation and in a manner that other motor tracts have not been interfered with the picture of the paralysis due

thereto would not differ from a primary nuclear paralysis, and could not be distinguished from it. But, on the contrary, when the roots of ocular nerves are interrupted in their course, in parts which form the paths of other motor nerves—by lesions by which both are injured, the result would be characteristic. From such a complication there would arise a paralysis of the muscles supplied by the third nerve in the eye of the corresponding side, while there would also be paralysis of the extremities in the opposite side.

In such a case the lesion may be located in the lower part of the cerebral peduncle, through which the third nerve passes, the disease extending to the pyramidal tract. Alternate paralysis as has just been described may also be caused by disease beginning at the base of the brain, by which the third nerve would bear the first attack and the peduncle would be consecutively involved. The behavior of the inner muscles of the eye, however, would decide whether the case is one of fascicular or of basilar origin. In the former event the pupil and ciliary muscle would remain exempt, in the latter they would take part in the paralysis.

Alternating paralysis of the abducens and the extremities is attributable to disease of the bulbar portion of the pons. Basilar disease may implicate the pons and paralysis of the abducens, with paralyses of the extremities of the opposite side, ensue; but from such a cause a number of the other cranial nerves would also be affected, as has already been stated in the consideration of basilar paralysis.

I shall have to dismiss the consideration of ocular paralysis due to lesions in the cortical centers, and in the nerve tracts between the cortical centers and the nuclei, with very few words. This region of the brain so far as the cortical centers of the ocular nerves and the fibres passing therefrom to the nuclei are concerned, still remains a *terra incognita*. Mauthner, after carefully reviewing the physiological experiments of Hitzig, Ferrier, Munk, Carvillet and Duret, Hensen, and Volckers, and Arloing, says: "We can at this time only say that by stimulating various parts of the cerebral cortex certain movements were observed, and that by the destruction of certain parts of the cortex perhaps an impaired movement of the eye resulted. We can only say that we are far from fixing a cortical center for the muscles of the eye, on the basis of experimental investigations, and, therefore, from what we know of experiments upon animals, we feel unable to diagnose a cortical paralysis."

He further states, in commenting upon clinical histories and autopsies by Grasset, Laudouzy, Bramwell, Jaccoud, Coingt and others: "Neither do the clinical and pathological anatomical observations made upon man permit us to establish the diagnosis of cortical paralyses of the eye-muscles."

The Use and Abuse of Pepsin.—The physician who is too lazy or too busy to study out a case of indigestion or dyspepsia is very liable to fall into the routine habit of prescribing pepsin when it is not indicated. Dr. G. C. Barton, in the *Northwestern Lancet*, argues against its indiscriminate use and attempts to discourage the laity from buying it. It is harmful to use too much pepsin, as an excess of it in the stomach is a source of danger.

Treatment of Alopecia Areata.—Leistikow for the last four years has used chrysarobin almost exclusively in alopecia areata. The results (*British Medical Journal*) in total alopecia were satisfactory though not reliable; in the partial affection the cures were 58 per cent., but among these, relapses occurred in 30 per cent.; of these patients two-thirds were lost sight of, but the remainder were again cured and remained free. Formerly he only used the chrysarobin as a 5 to 10 per cent. ointment applied once or twice daily, but now he prepares a stick composed of chrysarobin 30, colophonium 5, cera flava 35, olive oil 30 parts, the application thus being more simple. Every evening the stick is rubbed over the affected part, which is washed clean with olive oil in the morning. In some days the skin often becomes irritable and red, when zinc ointment is substituted for a time.

A REPORT OF TWO OBSTETRICAL CASES.

Read at the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 24-27, 1894.

By Granville E. Dickinson, M. D.,
Of Upper Fairmount, Md.

Although labor is a natural function, and the resources of the organism are usually sufficient for its accomplishment, yet there are a number of circumstances which may interfere with the work of nature and render the process difficult and dangerous to either mother or child—sometimes both. The two cases to which I am about to refer may not prove so interesting to those having an extensive obstetrical practice in lying-in asylums as to myself and probably a number of others present, who are limited in experience. To us such cases are rare and interesting. The first case to which I will refer is probably not so rare as I at first thought, as I find Dr. Lessing, of Philadelphia, reports a similar one.

On the 5th of February, about 7 P. M., I was called to see Mrs. W——, the mother of five children, and all delivered without any special trouble. During the last pregnancy her general health was good. She attended to her household duties, cooking, etc., until a few days before her labor; but during the last two or three months she had a dread that something was wrong, as she expressed it, yet she could give no reason—only that she felt different from what she had done in any of her previous pregnancies. The first warning she had that labor was about to begin was the rupture of the membranes. A messenger was immediately started for me, two miles distant. When I reached the house (which was probably not more than two hours after, although it was a very dark and stormy night) the nurse informed me I was too late—the baby was born and dead. Upon inquiry I learned the child had been delivered nearly an hour, the placenta still not delivered, and the woman having strong pains. I found the uterus firmly contracted on a large body of some kind, which I naturally concluded was another fetus. A vaginal examination proved my conclusion to be correct. The head was presenting at the superior strait, and the membranes not ruptured. The labor progressed rapidly, and the child was soon delivered alive. I then compared the two, and the dead fetus, I think, must have been less than seven months old, as it was very small compared with the other. We had no means of weighing it, but concluded it would not weigh more than two pounds. It was eleven inches long, and the testicles had not descended. The second was a well-developed child, twenty-one inches long, and probably weighed seven or eight pounds, and both testicles had descended. I then examined the placenta, which was delivered without any trouble by making a little pressure over the fundus, and found that each fetus was inclosed in a separate sac, and each had a separate placenta. Although the two were slightly joined together, the line of demarcation, which was only about an inch long, was very distinct, and showed plainly that they had once been entirely separate; the one to which the living child was attached, and by which it was nourished, being more than double the size of the other. These facts bring to my mind a very interesting question: Were these two different conceptions, one of them two or three months after the other, or had one fetus been dead two or three months? Some writers say one may die and the other continue to grow, and in such cases, which are very rare, the dead body may remain in the uterus, where it hardens, withers and is expelled during labor; but in this case it was neither hard nor withered, and had the appearance of only having been dead a few hours. Yet I believe it had been dead two or three months, because the woman had not menstruated for nine months, and

some writers claim that a dead fetus may remain in the uterus for several months without change.

Only a few days ago I was consulted by a lady who said her menses had failed to appear for four months; but in March they appeared, and again in April, when the amount of blood she was losing alarmed her. She was also having some pain. On examination I found the os slightly dilated and the uterus contracting. She was soon delivered of about a three-months' fetus, which must have been dead about three months, and remained in the uterus that length of time without causing contraction. The woman had felt no movements, and said she had no reason to think she was pregnant, except the non-appearance of the menses; but in this case there was considerable discoloration of the fetus, no hardening or withering.

The next case to which I will refer is peculiarly interesting to me. The woman, a primipara, short and rather stout, had excellent health during her pregnancy, attended to her household duties until the day before her labor commenced, which was at 1 A. M., and progressed slowly but apparently normally. The contractions were not strong, yet the os seemed to be dilating gradually. About 3 P. M. the pains increased very much in strength yet they seemed to have no more effect on the os. The pelvis was natural, the head was presenting in the first position but would not enter the superior strait. At 6 P. M. there was no change, the os was rigid and the contractions did not press the head against it with sufficient force to overcome the rigidity. I administered an anesthetic and dilated the os with the assistance of Dr. R——. The pains at this time were getting very strong, yet the head would not engage and could be changed to almost any position even during the contractions; for this reason I then proposed version, thinking it would be easier than the forceps, as the os was rigid and not dilated sufficiently to get the forceps on the head. The anesthetic (chloroform) was administered again; after making the necessary arrangements and using the proper antiseptic precautions, I introduced my hand and found I could pass it all around the head, even during the pains, without any difficulty, but when I reached the neck I found a rigid contraction similar to the contraction which sometimes takes place during the third stage of labor, usually termed hour-glass contraction. After considerable difficulty I succeeded in dilating this sufficiently for my hand to pass far enough to feel the pulsations of the cord, which was around the neck. I could also feel the pulsations of the fetal heart. I tried to remove the cord from around the neck but the spasmodic contraction was so strong I was compelled to remove my hand; the pressure had almost entirely destroyed the sense of touch; this of course rendered version impossible. I then decided to try the forceps, although I thought it would sacrifice the life of the child, as the head was still above the superior strait, and to dilate the spasmodic contraction it would be necessary to make constant traction on the head, and the cord being around the neck, would be pressed between the stricture and the shoulders, which would of course stop the circulation. I applied Hodge's forceps without any difficulty, the woman still being under the influence of the chloroform, and by making gradual but constant traction the stricture was dilated sufficiently for the shoulders to enter and the delivery was soon completed. On examining the fetal heart I thought I could perceive some slight pulsations, but no respirations. All efforts to resuscitate proved fruitless. The placenta was delivered without any trouble, by simply making a little pressure over the fundus as in the other case, although there was still some spasmodic contraction. There are several interesting points in this case. The woman informed me that she had two sisters, both of which, after a protracted and hard labor, had been delivered of dead children.

I could not learn the cause or get any further history of either case, but it brings to my mind this question: Why should these three sisters during their first labor be so much alike, each having a very tedious, and a very hard labor,

and at last be delivered of a dead child? Is it not possible and even probable the cause may have been the same, but not discovered in the other two cases? But the most important question I think is: What is the cause of such abnormal contractions during the first stage of labor? Cases of this kind, I think, plainly show the dangers of ergot in the hands of ignorant midwives, who are not familiar with the dangers of the drug, and only know it will increase the pains. I am sorry to say some physicians are also in the habit of giving it during the first stage, and subjecting their patients to the various dangers of the drug. Abnormal contractions, as in the case to which I have referred, are not likely to be discovered during the first stage. My reason for referring to this subject is because an old midwife, who was present several times, asked me the question why I did not give ergot, and referred me to a physician who she said always gave it in tedious cases. Had I followed her advice, it would probably have increased the spasmodic contraction, may have caused one continuous pain, which would certainly have exhausted the woman, may have caused convulsions, rupture of the uterus, or some other serious trouble. For this reason I think every practitioner should be very careful in using the drug, and adopt every means possible to prevent its use by those ignorant of its dangers.

SOCIETY REPORTS.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND.

NINETY-SIXTH ANNUAL SESSION, HELD AT THE HALL OF THE FACULTY, BALTIMORE, APRIL 24 TO 27, 1894.

Dr. Samuel J. Fort read a paper entitled CLINICAL ASPECTS OF IMBECILITY.

Dr. George J. Preston, in connection with this paper, said he would like to say something about State care of epileptics. As we know, there is hardly any other class of cases in the community that is more unfortunate than epileptics; more so than the insane because the latter have a place of refuge; the epileptic, on the other hand, is not admitted as a rule. He is left to his family. Most physicians present know of epileptics who are kept in families and it is a hardship for them. Poor people are not able to feed and clothe one that is not productive. The epileptic cannot take up any trade nor is he admitted to any service because of his infirmity. We have done a great deal for the insane and the Lunacy Commission of this State are very active, but nothing has been done for the epileptic. In other States, as California, New York, and Ohio, epileptic colonies have been started and the King's Daughters, in this State, have just had a piece of land given them and have started a home for epileptics. If people knew of it they would give it aid. It is started in a very simple way.

Dr. S. J. Fort said it would be a good idea to emphasize what Dr. Preston has said. These epileptics belong to the dependents of the State, and there are many good arguments in favor of institutional care of that class. In other ways they would succeed in curing curable cases except where the physician has the cases under his eye. There are other things than the giving of drugs. Exercise and diet must be watched and that cannot be done at home, and society at large should be protected from them. These should be protected from damage and should be isolated for the sake of others.

Dr. George J. Preston then read a paper entitled NOTES ON HEMIPLEGIA.

Dr. J. H. Branham thought that points in the differential diagnosis had not been brought out. The condition of the pupils was one of the most important diagnostic signs. Macewen, of Glasgow, pointed this out as the result of his large experience. In alcoholism the pupils dilate alike on the two sides and they dilate when turned to the light. The temperature is below 90°; there is a spasm of the extremities.

Dr. Preston regarded the condition of the pupils as a very unreliable symptom; it is only slightly suggestive.

Dr. John C. Hemmeter read two papers,

(*a*) The Natural Occurrence of Fatty Degeneration of the Heart-Muscle in Animals, and (*b*) Over-Exertion of the Heart.

Dr. Joseph Friedenwald then read a paper entitled Atony of the Intestines. Atony of the stomach and intestines is a disease long known ; it may be primary or secondary. It may be caused by too little food or too much liquid ; too little liquid and improper hygienic conditions ; sedentary habits ; too frequent use of cathartics cause irritation of the bowel ; diseases of the heart, lungs and liver may also cause it and it comes after typhoid fever, dysentery and cholera, and it may be due to cancer of the stomach. In early childhood it occurs as frequently in males as in females. In the aged, constipation is often the only symptom, when there is a long time between the stools. The symptoms are headache, loss of appetite, nausea, pain in the back and loins ; auto-intoxication ; the abdomen is filled with gas. The hard fecal mass may be felt through the abdominal walls. The stools are darker and dryer than usual. The treatment depends on the cause. Constipation is the prominent symptom. Simple measures are necessary. They are first hygienic and dietetic. Walking and gymnastics and the use of such foods as stimulate, as fruits and vegetables, Graham and rye bread, cold water in the morning. Glauber salt and Marienbad water, saline water, Kissingen. Do not give red wines, tea or rice. Use abdominal massage and exercise every day. Use electricity every other day over the abdomen. Use injections of olive oil, injecting it in slowly and having it slightly warm and let it be retained several hours. The patient should remain several hours lying down after the oil injection has been given. Use also soap and water and exercise. Cathartics should be used as little as possible. Cascara sagrada is the best, as it does not constipate afterwards. Use tonics, as strychnia and belladonna, to give tone to the intestines.

Dr. P. C. Williams thinks that cascara sagrada is one of the best cathartics. It is certain and does not constipate, and the dose does not have to be increased. Atony of the intestines is much more common in women than in men, and especially in school children.

Dr. Robert L. Randolph then read a paper on Albuminuric Retinitis ; Its Significance and Pathological Histology. He reported several cases in which sight had been entirely lost, and in which the first signs of the trouble had been found in the eye even before the urine showed any signs. It was necessary in some cases to cause premature delivery to save the eyesight and life. This trouble may occur in one labor and not in another in the same woman.

Dr. George B. Reynolds said that nothing was so bad as to find a case of eclampsia during the pregnancy. It was a question whether the uterus should be emptied or not. Also, should the woman be allowed to become pregnant again ? It is as in cases of deformed pelvis : it is not easy to advise. And, if so, should premature labor be brought on, and at what period ?

Dr. P. C. Williams thought it was very hard to give advice.

Dr. Wilmer Brinton said that in certain cases it was not necessary to bring on premature labor, but he thinks it is customary to put it off until too late. He had had two cases in the past year in which it was put off too long, and one case died soon after the birth of her child and one was blind.

Dr. W. B. Canfield thought that the paper showed the importance of a knowledge of the use of the ophthalmoscope on the part of the general practitioner. He examined much urine in the course of a year, and often suspected a pre-albuminuric state when he could not find albumen in the urine, and in just such cases he thought an examination of the eyes would make a diagnosis when the urine looked normal.

Dr. E. J. Bernstein also thought the general practitioner should know how to use the ophthalmoscope.

Dr. John D. Blake had called attention to this class of cases before.

Dr. Randolph did not give advice as to whether the woman should become pregnant again or not, but simply told the

woman of the gravity of the trouble and let her decide. He only spoke of those cases which showed the symptoms in the eye because the eye trouble was found four weeks before the urine symptoms.

Dr. Joseph H. Branham read a paper entitled INTESTINAL OBSTRUCTION, with report of an interesting case.

Dr. Randolph Winslow said the case just reported was a very important one. Every one will agree with him that the only thing to be done, after medical means had failed, was to operate, and it should not be delayed too long to be effective. The conditions are grave, and a successful result is not always obtained. The first case he operated on recovered, and many of them died, and he thought that Dr. Branham ought to be congratulated on the result of his operation. Not more than one in four or five recover.

Dr. Branham would like to refer to one point in Dr. Winslow's statement, and that is the mortality. He did not think the mortality was as great as Dr. Winslow says, for if we operate early the death rate is much less.

Dr. J. W. Chambers then read a paper entitled TWO CASES OF PRIMARY RESECTION OF THE INTESTINES FOR GANGRENE.

Dr. J. C. Harris reported two cases of the same kind.

Dr. S. T. Earle referred to a case of gastro-enterostomy of his, done by Dr. F. C. Bressler with the Murphy button, and which seemed to be successful.

Dr. Randolph Winslow then reported GUN-SHOT WOUNDS OF THE INTESTINES; LAPAROTOMY; RECOVERY. The man was over sixty. Four wounds were found. This was the first case of its kind in Baltimore to recover.

Dr. L. McLane Tiffany then reported cases of ABDOMINAL GUN-SHOT WOUNDS WITH EXHIBITION OF PATIENTS.

A white male, aged 20 years, received a pistol bullet a little to the left and below the navel—the bullet passed transversely across the body. I saw the case about two hours after the injury was received. The patient was lying in bed on the side, but rolled over when requested. There had been no vomiting, although the patient was shot shortly after dinner. The skin was discolored by powder, so near was the pistol to him when discharged. Respiration was costal; the belly walls rigid. He was sent to hospital and opened by long, vertical incision passing through the bullet wound. Nine wounds of the small intestine were found and four of the mesentery; two of the latter bled very freely; much blood was in the belly. The wounds in the small intestine were closed by continuous Lembert suture or Cushing's rectangular suture, the abdomen flushed out and the wound closed. The bullet was not found. The patient had stitch abscess, ultimately recovering.

The second case was a negro, male, aged 20; was shot with a small rifle in the hands of a companion who was distant about 20 feet almost directly behind. The bullet entered the back three inches from the spine just below the last rib, left side. He was brought at once to the hospital, where I saw him four hours later; the resident physician having cleaned both patient and himself, had enlarged and explored the wound, finding that the bullet had passed into the abdominal cavity, wounding the kidney. On my arrival I found that the patient's breathing was slightly faster, perhaps four respirations to the minute, than when he came in—no other change however—pulse 80. I explored the wound, found the kidney wounded and that the ball had continued forward. This wound was then filled with gauze, the patient was then turned on his back and the belly opened freely by an incision along the outer border of the left rectus muscle. Blood was in the abdomen—no wounds of the intestines were found. The bullet had passed entirely through the spleen; there was free bleeding. I carried a long, curved needle through the spleen parallel with and half an inch from the bullet wound, and tied it around the free border of the spleen, pressing together the splenic substance and so obliterating the track of the wound by pressure. Hemorrhage ceased when this ligature was tied. The abdomen was then cleaned and the pa-

tient returned to bed. Recovery was uneventful. Urine passed from posterior wound for two days.

Dr. W. S. Halsted then read a paper entitled OPERATIVE TREATMENT OF CANCER OF THE BREAST, in which he advocated the entire removal of the pectoralis major and part of the pectoralis minor and cleaning out all the glands from the axilla. His results had been good.

Dr. J. C. Bloodgood read a paper entitled OPERATIONS FOR THE RADICAL CURE OF HERNIA, WITH EXHIBITION OF 25 CASES CURED BY THE HALSTED METHOD.

The only great advance in the operation for hernia since the days Heliodorus are the operations of Macewen, Halsted and Bassini. The last two surgeons seem to have started off with the same ideas, but which have resulted in operations very much the same. Both surgeons recognize the chief cause of hernia, the rings and the inguinal canal which they obliterate and make a new internal ring and a new canal. Bassini's idea, after ligating the sac high up is to make a new canal whose obliquity imitates nature. Halsted, recognizing the fact that the cord must be preserved, transplants it to what he considers the place where it will interfere least with the firm union of the abdominal wall, which he treats on the same principle as any other laparotomy wound; that is, the sac is excised and closed at its neck as one would close any other rent in the peritoneum; the incised muscle, above the internal ring, through which the cord passes, the walls of the inguinal canal and the pillars of the external ring are approximated by buried mattress sutures and additional sutures are placed in the aponeurosis of the external oblique. The cord lies between skin and aponeurosis. Halsted's operation seems to have advantages over Bassini's. *First*, in Halsted's operation the cord is transplanted higher in the muscle, which is incised 3 to 4 c. m. above the internal ring, therefore making the near internal ring, always a weak point in the strongest place, for it is now well recognized that the union of raw muscle surfaces makes the strongest laparotomy wounds. Bassini only brings the cord out at the level of the old ring where the muscle is very thin. *Second*, Halsted excises the veins and thereby reduces the size of the cord and therefore of the internal ring, one-half to three-fourths. *Third*, Bassini, hoping to imitate nature, places the cord between the external oblique muscle and its aponeurosis. This position has decidedly the disadvantages, it must weaken the union of these tissues, the strength of which prevents the return of the hernia. The circulation in the cord must be more impeded lying between two rows of sutures than between skin and aponeurosis. These two operations promise to be the modern treatment of hernia. At the Johns Hopkins Hospital, since June, 1889, there have been 87 operations on males by Halsted's method, with four returns and in three of these cases there were stitch abscesses and not primary union. The fourth case got out of bed on the sixth day and had to be discharged from hospital. There have been performed at the hospital 110 operations for inguinal hernia and no deaths. Of these, 87 have just been noted; twelve were in women, none of these have returned. In six cases castration was also done with no returns, and in five the cord was not transplanted; three of these have returned, two of which were strangulated, and in seven in whom McBurney's operation was done, two have returned.

Dr. Harry Friedenwald then read a paper entitled EYE SYMPTOMS IN DIABETES MELLITUS. (See page 46.)

Dr. James T. Whittaker then delivered the Annual Oration on PREDISPOSITION TO TUBERCULOSIS. (See pages 39 and 65). This was followed by the annual banquet.

Dr. G. E. Dickinson, of Upper Fairmount, Md., then read a REPORT OF TWO OBSTETRICAL CASES. (See page 104.)

Dr. Hunter Robb then read a paper entitled ASEPSIS IN MINOR GYNECOLOGICAL PRACTICE. (See page 82.)

Dr. A. K. Bond said he believed that most private practitioners were culpably careless in the matter of simple asepsis in hypodermic injections,

cauterization, vaginal examinations, etc. The minute details of hospital practice are not suitable for private practice and that they are not at all applied is evident from the still great average mortality in civilized countries from parturition. With patients free from septicemia and instruments not previously used in septic cases very simple cleansing with hot water or soap and water is sufficient. He himself in twelve years of practice had never had an abscess after hypodermic injection. He had had one in hospital in a man already pyemic. When instruments have previously been infected with septic matter most careful disinfection is necessary, as by the passage of pure carbolic acid through the syringe needle from the syringe and subsequent washing with water. In general private practice a great advance would be made if physicians could be induced in ordinary cases simply to wash the syringe, catheter, etc., with hot water or soap and water, and similarly to wash the skin,which is to be pierced, the vulva in vaginal examinations, and the parts about the urethra in catheterization. A small number of bacteria will be overcome by healthy tissues if they are not possessed of very intense septic powers through associated matters or otherwise. In ordinary healthy patients and when the physician's instruments and hands have not been intensely poisoned by previous cases, the removal of impurity in its gross form is all that is necessary and is certainly more than is usually secured by ordinary general practitioners outside of hospitals.

Dr. William T. Cathell being absent, his paper on RECENT STUDIES ON NASAL AND POST-NASAL OBSTRUCTION was read by title.

Dr. E. J. Bernstein then read a paper entitled WHEN AND HOW SHALL WE CORRECT OCULAR MUSCULAR INSUFFICIENCIES? in which he reviewed the writings of Roosa, Stevens, Savage, Gould and Theobald and advised against the operation of graduated tenotomy under any condition. Only ten per cent. of heterophorias were found requiring any notice whatever, besides the correction of various degrees of ametropia. Only one case in 150 resisted treatment other than complete tenotomy; a number of cases were reported in which very high degrees of heterophoria caused no annoyance after the focal condition was rectified.

Dr. George J. Preston said that such cases were constantly brought before the neurologist and nothing definite seems to be decided. The advocates of tenotomy seem to be too decided and made too great claims, saying that they had cured many cases of chorea and many forms of insanity. He did not think that eye-strain was a common cause of these troubles. Headache is most frequently caused by eye-strain.

Dr. Herbert Harlan said he should like to defend such men as Stevens and referred to ten cases in children due to eye defect and only one was due to defect of the eye muscles and others had been reported. He took exception to Dr. Bernstein's treatment by the prism. The prism will relieve a case with a tendency to squint, but it will be necessary to increase the strength of the prism.

Dr. Bernstein thought that Dr. Harlan had missed the point of what he said. He quoted but one case of squint in which he had used the prism.

MEDICAL PROGRESS.

CORROSIVE SUBLIMATE AND GRAY OIL USED HYPODERMICALLY IN SYPHILIS.—Dr. Orville Horwitz, in looking into the value of these two substances in treating syphilis, concludes in the *Therapeutic Gazette* that :

1. Hypodermic medications will not abort disease.

2. It should not be employed as a routine method of treatment.

3. That the production of abcesses or of ptyalism by this method must be very rare.

4. Injections of corrosive sublimate give rise to trifling pain, but not to callosities.

5. The gray oil gives rise to slight pain and always produces induration.

6. The gray oil employed in this man-

ner is more dangerous than corrosive sublimate, and when administered the patient should be carefully watched.

7. In suitable cases, when properly employed, these remedies are among the strongest weapons possessed by the profession wherewith to fight the disease.

8. When employing corrosive sublimate, a quarter of a grain should be administered with each injection, provided the patient has not previously been submitted to treatment; if mercurials have already been employed by the mouth, the quantity employed should be one-sixth of a grain.

9. Hypodermic injections of corrosive sublimate are of undoubted value when the lesions appear upon the face and a rapid impression is desired; likewise when some important structure, as the eye or brain, is attacked.

Mercurials may be employed hypodermically as a substitute for inunctions in a systematic course of treatment.

They may be used with advantage when time is an object.

In cases of relapsing syphilis where other methods have failed, injections have completely controlled the outbreak.

In syphilitic diseases of the nervous system their use generally produces most satisfactory results.

They are frequently beneficial in those forms of eruption that have proved rebellious to other treatment.

10. It is well to employ the gray oil in cases of severe secondary syphilis where there is evidence of a tendency to relapse during the course of a two years' treatment, winding up with a weekly administration of a hypodermic for the space of six weeks. The patient should then be placed upon small doses of iodide of potassium for the period of three months. This treatment is valuable in the obstinate relapsing tertiary variety of the disease, and has proved more potent in our hands than any other method. In nervous syphilis it is far superior to inunctions.

Finally.—This mode of treatment is unhesitatingly recommended to the profession, under the conditions already laid down, as the most reliable and active that can be employed.

The Hypodermic Treatment of Syphilis.—As a result of a discussion between Drs. J. Wm. White and Dr. L. Wolff, of Philadelphia, the former being opposed to, and the latter in favor of, the hypodermic method of treating syphilis, Dr. Wolff takes up the subject of in favor of his side by addressing letters to syphilographers the world over with the result of receiving forty-four replies and from a study of these letters he records in the *Therapeutic Gazette* his conclusions, as follows:

1. The hypodermic use of mercurials is largely employed in the treatment of syphilis in Continental Europe, with probably the exception of France.

2. While all of the many preparations of mercury find employment in this treatment, the one by preference is sublimate, next in order calomel, then salicylate, followed by yellow oxide, also sozoiodolate and gray oil; the others seem to be favored by individual adherents only.

3. That there appears to be a decided preference for the soluble over the insoluble preparations.

4. As to rapidity of action and permanence in effect, calomel seems to hold the foremost place.

5. There seems to be no doubt, judging from my investigation, that in that part of the European continent mentioned the hypodermic method (I include here also the intramuscular injections) is being freely employed as a general treatment for syphilis.

6. The period of time through which the hypodermic treatment is being continued in the average cases cannot be said to be strictly limited, but should be until all symptoms have completely disappeared.

7. The opinions of my correspondents on the disadvantages and untoward effects of this treatment would show that they are not nearly as frequent or as serious as has been supposed, and that they are by far more frequent with the insoluble than the soluble preparations. It seems to be the general opinion of a majority of my correspondents that serious complications may be avoided with proper care and cleanliness. The testi-

mony of a few individual ones seems in this respect greatly at variance with the experience of a large majority. Accidents such as may arise in the course of all methods of mercurialization cannot, of course, be especially attributed to the hypodermic treatment.

8. The question as to the firm basis on which the hypodermic method is established is answered almost universally in the affirmative.

9. The consensus of opinions of my correspondents as to whether the hypodermic method should be continued or abandoned as a regular treatment for syphilis tends towards the almost universally expressed desirability of its continuation, although in the minds of a small minority with certain limitations or restrictions.

10. There seems no doubt, from the nature of the responses I have received and quoted above, that I was justified in claiming some time ago "that in the principal medical centres of Continental Europe little or almost no mercury is given internally any more in the treatment of syphilis," and that in the countries mentioned hypodermic medication has superseded oral ingestion of mercurials to a great extent.

* * *

Heart Disease and Menstruation.—Dr. Gow recently read a paper (*Lancet*) before the Obstetrical Society of London with a record of 50 cases. In 28 the menstrual flow was unaltered ; in 17 the flow was absent or scantier than before ; in 5 the flow was either more profuse or recurred more frequently than before ; in no case was there good evidence that heart disease gave rise to severe menorrhagia. It would seem that either amenorrhea or scanty menstruation was a far more common accompaniment of heart disease than menorrhagia. A further analysis of these cases seemed to point to the fact that heart disease led to relative sterility, and also that it greatly increased the tendency to premature expulsion of the ovum. In conclusion, it was pointed out that a large number of women suffering from valvular disease of the heart pass safely through the period of pregnancy and labor. The cases were further analysed as follows : 1. Mitral stenosis (22 cases) : in 9 cases menstruation was regular and the amount lost unaltered, in 5 cases menstruation was regular but more scanty, in 4 cases there was amenorrhea, and in 4 cases menstruation was either more frequent or more profuse. 2. Mitral incompetence (15 cases) : in 10 cases menstruation was unaltered, in 4 cases menstruation was more scanty, and in 1 case there was amenorrhea. 3. Mitral stenosis and incompetence (7 cases) : in 4 cases menstruation was unaltered, in 1 case menstruation was more scanty, in 1 case there was amenorrhea, and in 1 case there was slightly increased menstrual loss. 4. Aortic incompetence and obstruction (2 cases) : in both cases menstruation was unaltered. 5. Aortic and mitral incompetence (3 cases) : in all cases menstruation was unaltered. 6. Aortic incompetence and obstruction and mitral incompetence (1 case) : menstrual loss was more scanty than before.

* * *

Pitting of Small-pox.—The great danger in an ordinary case of small-pox is the pitting, which so often leaves indelible marks. Dr. S. G. Webber, in reporting several cases of this disease to the *Boston Medical and Surgical Journal* used the local application :

Acid. Carbolic. . .	gr.v
Glycerin. . . .	
Aquae. . . .	ää ℥ j

This was applied freely several times a day to keep the crusts moist from the time the eruption became pustular or even sooner, and it had the effect of preventing the itching, smarting and burning and thus kept the patient free from the temptation of scratching.

* * *

Vinegar for the Removal of Fish-bones from the Larynx.—Schliep points out in the *British Medical Journal* that fish and other bones are reputed to lose their hardness when acted on by vinegar. By experiment he found that already after fifteen or twenty minutes small fish bones are softened by vinegar at the body temperature. Fragments of bone require somewhat more time. An even more energetic action

was obtained with a one to five per cent. solution of hydrochloric acid, and in practice he recommended its repeated application in a two per cent. strength by means of cotton wool tampons. When the foreign body is situated in the œsophagus, or appears to have reached the stomach, repeated swallowing of the solution is advised.

* * *

Posterior Urethritis.—Acute posterior urethritis probably extends by continuity from the anterior urethra at about the sixteenth to twenty-fifth day from the beginning of the acute attack. Dr. F. Tilden Brown thinks that the symptoms of this trouble are at first overlooked and may not appear until the patient has indulged again in sexual intercourse. The treatment should be careful and systematic to avoid relapses. In the treatment, as mentioned in the *Journal of Cutaneous and Genito-Urinary Diseases*, suppositories or deep injections of cocaine or morphia should be used to relieve the tenesmus; benzoate of ammonia when the urine is alkaline, and bitartrate of potash when it is acid, are indicated. Sandal wood or salol should be given internally and later deep urethral injections of a weak solution of nitrate of silver. Examine the urine carefully and if mucous threads are found and if there is a tenderness on pressure over the membranous urethra or perineum, or if the urethroscope shows the lesion, a three per cent. solution of nitrate of silver on an applicator should be used for two or three days, or in some cases iodine will give better results.

* * *

Treatment of Procidentia Uteri.—The anatomy and physiology of complete procidentia uteri is very interesting, as is its mechanism, and this is appreciated when the treatment is studied. Dr. Grace Peckham-Murray (*American Journal of Obstetrics*) divides the treatment into non-surgical and surgical and gives the summary of this treatment as follows:

1.—Restore uterus to place. If sensitive and eroded, use antiseptic tampons of cotton. If tissues are soft and relaxed, astringents, as tannin and iodine, should be used. Heal the erosions with five per cent. solution of nitrate of silver. If the tissues are hardened by long exposure outside the vagina, astringents should not be used, but vaseline or some oily preparation should be employed.

2.—Massage has not been found of much benefit in these cases. If it is to be of use the improvement will be immediate. It would not avail in cases where there is a congenital tendency to displacements, but in those in which involution has not gone on to completion, or there is trouble with the circulation, massage or gymnastics may be of use.

3.—Pessaries which are well fitting may relieve the patient greatly, and should be used as soon as possible, as they hold the uterus better in place than any tampon. Many patients are made very comfortable with pessaries, which they learn to take care of themselves, and some cases have been cured after a time by the support of the organ, the congestion has been relieved, the tissues have become normal, and the ligaments have regained their tonicity.

4.—The surgical procedures from the earliest times have been without number. Many have become obsolete. Not much reliance has been placed upon those which simply narrow the vaginal outlet. The most serviceable of all these is the Le Fort operation. Many surgeons perform high amputation of the cervix, and combine with it, if the case would seem to demand, some of the operations for narrowing the vagina. The shortening of the round ligaments is generally conceded at the present day as not applicable to the cure of complete procidentia, and many believe that the time is not far distant when it will cease to be considered. Conservative surgeons regard ventrofixation and hysterectomy as measures too radical to be employed generally, and the success of vaginal fixation, as recommended by Schücking and many others who have followed his method, has not been established. Gynecologists will look for the results of the new and simple procedure recommended by Freund with the greatest interest.

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See also Publishers' Department, Page 118.

BALTIMORE, MAY 26, 1894.

Tuberculosis in Children.

It is always interesting to notice the different ways in which the same disease attacks children and adults. Tuberculosis usually appears in adults in the form of pulmonary consumption, and Louis long ago pointed out that in adults the lungs were equally if not more affected than any other organ. Dr. J. Walter Carr, in discussing before the Medical Society of London (*Lancet*), the starting points of tuberculous disease in children, notices first, in adults the enormous predominance of phthisis, the comparative tendency to a localization of the disease in the lungs and the subordinate part taken by gland disease in the adults. The opposite picture is seen in children. In them pulmonary consumption is not so very common as compared with other forms of the disease, and when it does occur it is not often primary and does not run that definite course from apex to base.

Out of 120 cases in children, in 32 the disease was more or less generalized; in 13 the glands were alone affected. While in adults the bacilli generally enter the organism by the respiratory tract, in children, and especially in infants, the disease is more general and the primary lesion may be in several organs at once.

The most important general conclusions to be drawn seem to be these: 1. That tuberculous disease in children commences usually in the glands, the liability being at its maximum during infancy and early childhood and rapidly decreasing in later childhood. That caseous glands, especially the internal ones, may (*a*) remain quiescent for an indefinite period; (*b*) start tuberculous mischief in adjacent parts, especially the lungs, by direct extension; and (*c*) set up general miliary tuberculosis.

2. That the internal glands, at any rate, are probably most often infected directly from the organ with which they are connected, although the possibility of infection through the blood stream must not be forgotten.

3. That tuberculous disease starts much more frequently in the thorax than in the abdomen, and certainly far more often in the thoracic than in the mesenteric glands. We must avoid being misled by the far too frequent use of that much-abused term, "consumption of the bowels," which, as employed by the laity, indicates simply marasmus due to improper food and very rarely any tuberculous lesion.

4. That glandular disease may often exist alone and quite unsuspected; in very many cases, doubtless, it is quite impossible of diagnosis; still, in dealing with obscure febrile conditions in children it is well to realise the very definite possibility of the symptoms being due to caseation in glands, to make every effort to discover their existence, and to use appropriate medicinal and climate treatment.

5. By far the most important treatment is the prophylactic. We may aim at excluding sources of infection in milk, raw meat juice, etc., and, still more important, in the air; but, do what we can, under present circumstances bacilli must obtain access—they are probably too omnipresent to be excluded. We must therefore increase the resistant powers of the system to their entry, above all by keeping the mucous membranes healthy. Whether the glands get infected directly through the lymphatic channels or indirectly through the

blood stream, the organisms must in every case have passed in through the mucous membrane, and through a healthy one they probably cannot penetrate. We have, therefore, to try to prevent gastro-intestinal and respiratory catarrhs, and especially to avoid their becoming chronic; to deal promptly with, and if possible to prevent, rickets, the great cause of such catarrhs in early childhood; and to take especial care of children during convalescence from measles, whooping-cough, and other acute specific diseases, so liable to depress the vitality of the body generally, and the resistant power of the mucous membranes, as well as the filtering power of the glands in particular.

* * *

Responsibility of Operators.

THE occasional suits for malpractice brought against reputable surgeons by friends and relatives of those who have died under the knife are, in many instances, greatly to be deplored. Cases are on record where a woman, for instance, has understood thoroughly the operation to be performed and has not only expressed her willingness to undergo it but has demanded it, assuming herself all risk, and yet after an unsuccessful result, the surgeon is served with a suit for malpractice and has no redress, but must appear in a court of law and even should he gain his case, as is not always done, his reputation must of necessity be affected and his skill called in question.

There shouldbe some uniform and written understanding or agreement between the operator and the person to be operated on or the responsible guardian of such person, and no surgeon should undertake an operation without seeing to it that such protection is assured. It is the custom with many surgeons who do a large number of operations, and particularly operating gynecologists, to have a book prepared for the purpose in which is a printed agreement setting forth that the person and his or her guardian understand thoroughly the operation about to be performed, and that they wish it to be performed and will exonerate the surgeon from all blame in case of an unsuccessful result.

This may appear to be a very one-sided arrangement, but it is natural to suppose that no one will make such an agreement with any but a reliable and trustworthy surgeon.

The plan is one which should be followed by all men whose extensive work and well-known skill not only attract a large *clièntele*, but whose wealth and reputation would make them a prey to designing persons who bring suits for notoriety. It would seem as if there were little trust in human nature when such agreements have to be made between the sick and the healer, but opinions are so liable to change before and after operations, and it takes so little to poison the average mind, and it is so easy in this country to enter suit against any one for almost any cause, that surgeons must and should do whatever is possible to protect themselves against unjust claims, which cause waste of time, damage to reputation and entail serious pecuniary loss.

* * *

THE effort to establish a National Bureau of Health seems to have settled down to a fight between the Marine Hospital and the New York Academy of Medicine. Dr. Wyman urgently opposes the formation of such a bureau on the ground that it is an additional expense and that the Marine Hospital is able to satisfy the requirements of such a service. There has always been a fear expressed that the Marine Hospital Service would object to this proposed bureau, and while all is tranquil and disease is at a distance, the National Bureau would probably be unnecessary, but in case of the ravages of cholera, yellow fever, small-pox and even typhoid fever, the Marine Hospital Service may find itself in need of help.

* * *

AT the meeting of the American Medico-Psychological Association last week, the old subject of tuberculosis in institutions was again brought up, and it was shown that tuberculosis is two or three times as frequent in such institutions as among the general population, and that many of the cases were started by living in infected hospitals, thus showing the need of good sanitation in these institutions. These facts should be borne in mind by those proposing to build a hospital for consumptives near Baltimore. Such an institution must not be a center of infection, and for this reason the dangers of infecting buildings must be considered when the plans of this new hospital are prepared. Good ventilation, plenty of sunlight, no dampness, good plumbing and drainage and compulsory exercise will all prevent the spread of infection in such institutions.

MEDICAL ITEMS.

There will be held an International Congress of Hygiene at Buda-Pesth next September.

*

The American Academy of Medicine will meet in Jefferson, N. H., August 29 and 30.

*

Dr. J. W. McLaughlin has been elected president of the Texas State Medical Association.

*

Berlin is said to be the healthiest city in the world, with a death-rate of only 16.3 per 1000.

*

The Governor of New York has signed the bill to appoint a commission to study tuberculosis in cattle.

*

Mr. Charles C. Harrison, of Philadelphia, succeeds Dr. William Pepper as provost of the University of Pennsylvania.

*

The successor to Sir Andrew Clarke as president of the Royal College of Physicians is Professor James Russell Reynolds.

*

Professor Wm. P. Tonry has been appointed analytical chemist to the Health Board as provided by the new Food Inspection Bill.

*

M. Pasteur is president of a committee of the City Council of Paris, to erect a monument to Charcot. The Council has given 1000 francs ($200).

*

The wife of an official of Osaka, Japan, and a graduate of the University of Ohio, is the first woman physician who has been permitted to practice medicine in Japan.

*

An apparently ignorant jury in Brooklyn has brought in a verdict in the case of a boy's death that it was caused by a complication of diseases accelerated by vaccination.

*

A special meeting of the New Jersey State Medical Examining Board will be held in Trenton, June 19, and it will be the last meeting before the new law goes into effect.

*

Dr. John de Butts died at his home in Queen Anne's County, Maryland, last Saturday in the sixty-seventh year of his age. Dr. de Butts was graduated from the University of Maryland in 1848.

It is against the law in Washington, D. C., for druggists to sell whiskey or other liquor, except on physicians' prescriptions. There are probably many prescriptions written for it.

*

Dr. Robert B. Morison has returned from Europe, to attend the meeting of the American Dermatological Association, of which he is president. After its adjournment he will sail again for the other side.

*

Dr. L. McLane Tiffany recently did his sixth successful intracranial neurectomy for intractable facial neuralgia. The reports of his first cases have been largely copied in journals in this country and abroad.

*

There are still some small-pox cases in Baltimore, more than the daily papers have reported, but not enough to occasion alarm and yet enough to lead every physician to insist on his patients being vaccinated.

*

A true philanthropist has given Dr. E. L. Trudeau $10,000 with which to build and equip a laboratory for the experimental study of tuberculosis at his hospital in the Adirondacks. He has also a fund of $1500 a year for this purpose.

*

At a special meeting of the Medical and Chirurgical Faculty held last Tuesday, some changes and additions were made to the Fee Table and resolutions were passed asking Congress to appropriate ten thousand dollars to the Medical Library at Washington.

*

Drs. G. L. Magruder, W. W. Johnston, E. L. Tompkins, James Kerr Mason, Henry F. Blount, H. L. West, E. Kurtz Johnson and Miss Waite have been elected members of the Board of Directors of the Central Dispensary and Emergency Hospital, at Washington, D. C., to serve for three years.

*

A board of medical officers, to consist of Major Joseph K. Corson, Surgeon, Major Valery Havard, Surgeon, and Major Edward B. Moseley, Surgeon, is appointed to meet at West Point, New York, June 1, 1894, or as soon thereafter as practicable, for the physical examination of the cadets of the graduating class at the U. S. Military Academy and such other cadets of the Academy and candidates for admission thereto as may be ordered before it.

BOOK REVIEWS.

THE IMPORTANCE OF EMPLOYING ANESTHESIA IN THE DIAGNOSIS OF INTRA-PELVIC GYNECOLOGICAL CONDITIONS, Demonstrated by an Analysis of 240 Cases. By Hunter Robb, M. D., Associate in Gynecology, Johns Hopkins University. Reprint from Johns Hopkins Hospital Reports.

This is a statistical report of a large number of cases examined before and during anesthesia, showing the advantage of the latter method. It fully illustrates the careful manner which the author employs, but the principle of conducting his work under an anesthetic is not a new one, and seems hardly worthy of such an elaborate report, especially from an author who is capable of so much stronger work.

THE PHYSICIAN'S WIFE; AND THE THINGS THAT PERTAIN TO HER LIFE. By Ellen M. Firebaugh. With portrait of author and 44 photo-engravings of original sketches. In one Crown Octavo volume of 200 pages. Extra Cloth, $1.25 net. Special Limited Edition, first 500 copies, numbered, and printed in photo-gravure ink on extra-fine enamelled paper; bound in Half-Leather and Vellum Cloth, $3.00 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

This is a good book for both the profession and the laity, for in it the dexterous author has vividly portrayed some of the many trials and hardships inseparable from the physician's life, and also given some interesting peeps into the domestic dilemmas and social troubles that beset his wife, and how they may be managed by the toil and business sagacity of a brave, ready-witted woman; all deftly woven into a garland of rich humor, keen sarcasm and touching pathos; delineating virtues, exposing vices, relating trials, and exulting over triumphs, in a style that mingles facts with fiction, as it glides smoothly from one theme to another. The whole book is both interesting and instructive and we congratulate its gentle author on her success, and sincerely hope it will be read by every physician, and every physician's wife, in our broad land. We predict for it a large sale, and congratulate the F. A. Davis Company on securing its publication.—D. W. CATHELL, M. D.

IN PRESS.

Mr. W. B. SAUNDERS, of Philadelphia, announces in preparation his New Aid Series of Manuals for Students and Practitioners, called The SAUNDER'S AID SERIES, which will not merely be condensations from present literature, but will be ably written by well-known authors and practitioners, most of them being teachers in representative American colleges. This new series, therefore, will form an admirable collection of advanced lectures, which will be invaluable aids to students in reading and in comprehending the contents of "recommended" works.

REPRINTS, ETC., RECEIVED.

Food Laws and Effects of Food Preservatives. By Henry Leffmann, Philadelphia.

Gouty Fingers. By Emil Pfeiffer, M. D., Wiesbaden. Reprint from the *Lancet*.

Wiesbaden as a Health Resort. By Emil Pfeiffer, M. D., Physician at Wiesbaden. Wiesbaden: J. F. Bergmann, 1893.

The Tariff and Administrative Customs Acts of 1890 and the Bill H. R. 4864, etc. Washington: Government Printing Office, 1894.

The Spectacle Treatment of Hypermetropia. By Boerne Bettman, M. D., Chicago. Reprint from *North American Practitioner*.

Subvolution, a New Pterygium Operation. By Boerne Bettman, M. D., Chicago. Reprint from *The Journal of the American Medical Association*.

Ripening of Immature Cataract, by Direct Trituration. By Boerne Bettman, M. D. Reprint from *The Journal of the American Medical Association*.

The Treatment and Cure of Chancre with Peroxide of Hydrogen. By Willard Parker Worster, A. M., M. D. Reprint from *Journal of Cutaneous and Genito-Urinary Diseases*.

Laparo-Hysterotomy; Its Indications and Technique. By N. Senn, M. D., Ph. D., LL.D. Reprint from *American Journal of the Medical Sciences*.

THE total number of cases of small-pox reported in Chicago from January 1 to May 14 is 1559 and it has assumed such alarming proportions that the State Board of Health has called a conference of clothing and textile manufacturers to co-operate in stamping out the disease in the sweat shops, and the factories are also seeing that all their hands are protected. The city of Chicago has appointed a large force of extra vaccine physicians and it is expected to have the whole city vaccinated in ten days.

*

A municipal reformer has proposed to use the garbage of his city as fuel to supply power to an electric plant. There is an element of economy concealed in this proposition that should appeal to the tax-payer.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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NOTES.

SALOPHEN, given in doses of fifteen to twenty grains every four to six hours, is said to remove the pain and swelling in acute articular rheumatism in a few days.

*

THE best chemical antidote for carbolic acid poisoning is Glauber salt or the sulphate of sodium, which forms with carbolic acid the sulpho-carbolate of sodium.

*

PIPERAZINE has been much vaunted of late as an effective remedy in the treatment of diabetes. If it actually has any effect in this disease, it will be what physicians have been seeking for a long time.

*

LACTOPHENIN is a new analgesic and hypnotic, which differs from phenacetin in that lactic acid takes the place of acetic acid. It is a white, tasteless powder, soluble in 320 parts of water. The ordinary dose is nine grains and may be increased to fifteen.

*

THE French and Germans seem to be very prolific in the production of coal-tar products, if reports are to be believed. Malakine, a new antiseptic, and neurodine, a new antineuralgic, are both laying claim to being unequalled by their predecesors. The names, as usual, give no clues to their chemical composition.

READING NOTICES.

Celerina, in teaspoonful doses, two or three times a day, will be found a valuable remedy in night terrors.

*

An Excellent Way.—The following is an excellent way to administer quinine, that is where one is desirous of having the disturbance of the nervous system, which frequently accompanies the administration of quinine, prevented:

℞—Antikamnia . . . . . ℥ss
Sulphate of Quinine. . . ℈ii

Make into twelve capsules. One every two or four hours, as may be indicated.

The antikamnia overcomes the headache and general disturbance so frequently produced by quinine, and in fact the conditions for which we give quinine frequently include headache, backache and aching of the limbs, and the antikamnia, being sedative in its character, relieves this.

*

Extract from article on Whooping-Cough, by J. P. Crozer Griffith, M. D., in American Text Book of Diseases of Children.—Antipyrine, first recognized by Sonnenberger, has been used with excellent results by so many that its value in the disease is now beyond question. Although, like other remedies, it often fails to relieve, many of the reported failures with it are doubtless due to the fact that it was not given in sufficiently large doses. Children bear it surprisingly well, and bad results following its administration are rare. The initial dose should be small and the amount gradually increased, until a child two years old receives from 1 to 2 grains, or even more, every three hours. In a desperate case of pertussis in a four months old child under my care, in which ¾ grain of Antipyrine, given every three hours, failed entirely to relieve, an increase of the dose to 1 grain every three hours rapidly brought the patient from a condition of the greatest danger to one of comparative health. The child had suffered from very frequent and violent attacks of cough, followed by spasms of the glottis of so long duration, that intense cyanosis with entire apnœa and loss of consciousness repeatedly resulted. Within 48 hours after the treatment had been instituted, the little patient had passed an entire night, and until afternoon of the next day, with but a single paroxysm.

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ORIGINAL ARTICLES.

EASY METHODS OF CARRYING OUT THE PRINCIPLES OF ASEPTIC SURGERY.

Read Before the Association of Military Surgeons, Washington, D. C., May 2, 1894.

By Robert Reyburn, A. M., M. D.,

Professor of Physiology and Clinical Surgery, Medical Department Howard University, Washington, D. C.

Nothing is more satisfactory to a surgeon of our day, in the daily round of his professional duties, than the performance of an aseptic surgical operation at one of the hospitals of our large cities. There he has trained medical assistants and nurses at his command, with an ample supply of sterilized surgical instruments and appliances, that fulfill all the requirements of the most exacting surgeon. He can leave his patient after the operation is over without a care or anxiety, knowing that every emergency will be met and that his patient will be just as well cared for during his absence, as if he were present.

But a little reflection must convince every thinking mind that if all this retinue of attendants, and wealth of surgical appliances, is necessary for the proper performance of aseptic surgical operations, then aseptic surgery is and must be for the great mass of the surgical operators of our vast country, merely a theoretical abstraction, and a failure as regards any practical utility to the surgeon. It should be remembered that the great bulk of surgical operations are and must be necessarily performed far from the hospitals of our great cities, and without the helps and appliances that some seem to consider so essential to success.

Consider for a moment the position of the surgeon to one of the great railroad systems stretching across some of our vast States for hundreds of miles. A collision or other accident takes place in the dead of night; he is summoned to instantly repair to the point where the maimed and wounded require his help; no time has he to summon to his aid trained nurses, nor is he able to bring with him complicated sterilized apparatus, but he must perforce use such simple appliances as he has at hand and make them answer his purposes.

The military surgeon after an engagement, the surgeon to a large manufactory, the surgeon on duty in a mining camp, and surgeons are engaged all over our country in numberless positions, in which for obvious reasons the finer technique so elaborately insisted on, and very properly so, in our large hospitals, is entirely impracticable and impossible of execution.

Admitting then, for the sake of argument, the condition of things above mentioned, the question then arises, "Is this elaborate technique necessary and can we not carry out the principles of

aseptic surgery in simpler ways, with just as good results to our patients ?"

It is my firm conviction that the elaborate technique insisted on by some is entirely unnecessary, and, heretical as the opinion may seem, that some portions of it are actually injurious to our patients. This remark applies more especially to the use of bichloride of mercury solutions to cut or abraded surfaces of the human body, which in the opinion of the writer of this paper should never be done. The use of bichloride of mercury solutions should be confined to the cleansing of the skin of the patient over the seat of a surgical operation, and to the cleansing of the hands and arms of the operator.

Recent investigations carried on at Johns Hopkins University (published in the *Johns Hopkins Hospital Bulletin*, of April, 1891, pp. 50-60), by Dr. A. C. Abbott, on "Corrosive Sublimate as a Disinfectant against Staphylococcus Pyogenes Aureus," on page 59, at the close of a very elaborate series of investigations on this subject, he says: "It is seen that under the most favorable conditions a given quantity of corrosive sublimate has the property of rendering inert only a given certain number of individual organisms." *Ibid.* page 60, he summarizes his results in the following words: "In the light of these experiments and those of the experimenters quoted in this paper, it is plain that for use in surgical practice the solutions of corrosive sublimate do not possess all of the advantages hitherto attributed to them. To the employment of the sublimate solutions upon wounded surfaces it is plain there exists at least two serious objections: First, the albumen of the tissues and fluids of the body tends to diminish the strength of, or indeed renders entirely inert, the solution employed; and second, the integrity of the tissues is materially injured by solutions of this salt."

Investigations made at the University of Michigan (published in the *Medical News* of October 1 and 8, 1892) have shown that solutions of mercuric chloride when used as a germicide are often inert, and still oftener actually injurious to the tissues, when applied during surgical operations.

Dr. Charles T. McClintock gives the above paper (*Medical News*, October 8, 1892, p. 399) the following summary of his experiments, viz.: "1. The high rank heretofore given to corrosive sublimate as a germicide is without warrant and was based on faulty experiments.

"2. The very varying power of resistance in different cultures, as pointed out by Esmarch and insisted on by Gruber, is an all-important factor to be noted in determining the germicidal power of any agent.

"3. That sublimate forms with cellulose, as cloth, filter paper, etc.; with silk, with albuminous bodies, with some part of bacteria (probably the envelope) a chemical compound that can not be removed by any amount of washing with water.

"Thus the sublimate, when acting upon a germ, forms a capsule around it that protects the germ for the time from the further action of the sublimate, and in turn forms an impenetrable barrier to the growth of the organism unless it be removed. This barrier may be removed with salines, and is more rapidly removed in proportion to the renewal of the salines; conditions that are fulfilled in the circulating blood.

"The above named experiments would seem to warrant the expression of the opinion that the use of solutions of corrosive sublimate in surgical operations should be limited to the cleansing of the surface of the part to be operated upon, and to the disinfection of the hands and arms of the surgeon; and furthermore, that such solutions should never be applied to surfaces denuded of epithelium, or cut surfaces of the body made during surgical operations."

Antiseptic surgery endeavors to destroy the micro-organisms in and around the wound and thus prevent their development. How futile this effort must be, when we consider that these organisms are everywhere and at all times present with us. They are in every breath we draw, in much of the water and in many of the articles of food that

we consume, and indeed exist always in the alimentary canal and all parts of the body exposed to the air. But on the other hand, it must be remembered that there are bacteria and bacteria. There are some species of bacteria which, when planted in a wound, will bring forth as the result of the poisonous materials formed by them, the formation of pus with the resulting septic fever, as certainly as the acorn when planted and nourished will develop into the sturdy oak. There are other species which when they come in contact with a wound are practically harmless. Of course we cannot with the naked eye distinguish between the poisonous bacteria and the harmless ones, and hence our only safe plan is as far as possible to exclude them altogether from wounds, whether made by violence or those made during surgical operations.

How, then, can this be done? The first point to be observed is, to use as little water or watery antiseptic solutions as possible in contact with the wounds made during surgical operations. The reason for this course is that by so doing we remove one of the essential conditions necessary for the development of bacteria, and thus prevent or at least hinder their growth. It is practically impossible to diminish or prevent the growth of bacteria in a wound by either raising or lowering the temperature of the wounded parts; hence we can only endeavor to accomplish this object by making use of the other two methods of limiting bacterial growth, viz.: to keep all wounded surfaces as dry as possible, and to exclude them from the action of the atmospheric poisonous germs, during the process of repair.

Simple and self-obvious as these principles of treatment may appear to be, yet they are largely neglected and ignored by very many surgical operators at this very time. Often during an operation performed even by the most eminent surgeons (let us say an amputation), we see the field of operation deluged with a solution of boric acid, a solution of carbolic acid, or worse still, a solution of mercuric chloride. This seems to me to be radically wrong in practice, and entirely inconsistent with the elementary principles of aseptic surgery. Of course, in operations which require the opening or removal of large suppurating cysts or cavities, it is necessary to wash them out. This should be done, we believe, with fluids as near the composition of blood serum as possible. That wonderful operator, Lawson Tait, of Birmingham, England, who has nearly completed his third thousand of operations upon the abdominal cavity, uses no fluid to wash out the abdominal cavity during his operations, excepting recently boiled water.

For use in surgical operations the following fluids only are necessary, viz.: recently boiled water used tepid (about the temperature of 100° F.) and normal salt solution (0.75 per 1000, easily made by dissolving one ounce, avoirdupois, of common salt in a gallon of boiling water).

Aseptic surgery, therefore, is after all nothing but cleanliness, but when we say that, we mean cleanliness carried to a microscopic degree of perfection, and far surpassing the ordinary ablutions by soap and water. What we endeavor to do at the present time, before any surgical operation, is to so thoroughly cleanse the patient, the surgeons, assistants, nurses, surgical appliances and dressings (of course, including the hospital and all its surroundings), that no germ of poisonous bacteria can infect the wound and cause suppurating fever, and perhaps the death of the patient operated upon. Modern surgery starts out with the assumption that in an operation aseptically performed upon an aseptic patient, and by an aseptic operator, there should be neither suppuration nor fever following any surgical operation. This is, of course, the ideal of surgery, which cannot always be realized, but nevertheless it is the goal towards which we should aim and which we should always endeavor to attain.

Every instrument and surgical appliance must be sterilized shortly before the operation, either by boiling in water containing one per cent. of carbonate of soda (commonly called washing soda), half an ounce to three pints of water, or

by being exposed to a dry heat above the temperature of boiling water (from 230° to 240° F.) for one-half hour before the operation.

This can be done in the various patterns of steam and dry sterilizers which are now on the market, and can be procured at a moderate cost. But my principal object in writing this article is to call attention to the fact that aseptic surgery can be practically carried out without the purchase of any apparatus whatever. A tin wash boiler, which can be found in the humblest home, is just as good for sterilizing surgical instruments as Arnold's or other of the steam sterilizers now in use. A still more simple sterilizer for small instruments is the ordinary oblong tin baking pan, so familiar to our eyes in our youthful days. This pan, when filled with boiling solution of carbonate of soda, may not look quite so ornamental as a porcelain evaporating dish, or a forty dollar copper sterilizer, but it will do just as good work. As before mentioned, to the above must be added absolute cleanliness of the operator, assistants, nurses, and in fact of all who come in contact with the patient. It is scarcely necessary here to say that the part operated upon, and the arms of the operator, assistants and nurses must be thoroughly scrubbed, first with soap and water, and then with solution of 1 to 2000 mercuric chloride just before the operation.

One incidental and very great advantage in operating in private houses, providing they are clean and in good sanitary condition, is that the germs of poisonous bacteria are for obvious reasons not so liable to be found there as in the air of crowded hospitals. In regard to the sterilization by the dry method, the only thing that is absolutely necessary to be purchased is a good thermometer, graduated to a temperature of 300° F. Of course it is convenient, and perhaps more surgical looking, to buy a dry sterilizing apparatus, but it is by no means essential. The oven of a kitchen range or that of an ordinary cooking stove will answer every purpose. Take a common pasteboard box, such as letter envelopes are packed in, place in the bottom of it a layer of aseptic cotton about two inches in thickness, lay on this your instruments and surgical appliances (bandages, etc.), with your thermometer, and your apparatus will then be complete. Place in the oven and expose to a temperature of 230° to 240° F. This temperature can be easily regulated by a little practice, and is lower than the temperature required for ordinary baking purposes, which is said to be 270° F.

A surgical operation is to a certain extent the opprobrium of medicine, for in having recourse to it we thereby confess the failure of our science. The ideal surgical operation, therefore, is one that removes the diseased or injured portion of the body with as little disturbance of the normal conditions of the tissues as possible. Repair without inflammation is, as all know, the motto of modern surgery. How preposterously absurd, therefore, is it for us after having removed, let us say, a tumor or limb from the body, to douche the seat of the operation with solutions of mercuric chloride or other powerful irritant, producing necrosis of the tissues and thus preventing the very end we seek to attain. To Professor Lister we owe the grand idea of excluding the bacteria and other germs from wounds, thus creating the new science of antiseptic surgery. It is perfectly true that aseptic surgery, as now practiced in this country and in Europe, is very different from, and far superior to, the cumbrous procedures and dressings devised and practiced by the father of antiseptic surgery. The carbolic spray, once universally applied, has been almost entirely abandoned, and during my recent visit to Europe I never saw it once used. The many layers of protective gauze, mackintosh, etc., are now replaced by a simple layer of iodoform gauze, with an abundant layer of aseptic cotton firmly retained by bandages.

Finally, allow me to add the following maxims:

1. Never use a drainage tube in a wound unless you are absolutely certain you cannot get union by first intention.

2. If you have an amputation to perform, ligate every vessel requiring it

with aseptic catgut, silkworm gut or silk; cut the ligatures off close to the vessels and leave them in the stump, close the flaps with similar sutures, and use no adhesive plasters in contact with the flaps of the stump.

3. After you have stitched up the flaps, dust their surfaces with iodoform, boric acid, or subnitrate of bismuth.

4. Place over this a layer of iodoform gauze, then an abundant layer of aseptic cotton, and over all this two layers at least of a well-fitting bandage. The reason why I do not use adhesive plaster in contact with the flaps of the stump is that it cannot be properly sterilized, and is very often the means of infecting the stump.

5. Above all things, never open a stump for ten or twelve or even fifteen days after an amputation, if the temperature of the patient is at normal point, or even a degree above. On the other hand, if the temperature goes up to 102° or 103°, open up the stump at once and find out the cause of the trouble.

714 Thirteenth Street.

SOME CLINICAL ASPECTS OF IMBECILITY.

Read at the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 24-27, 1894.

By Samuel J. Fort, M. D.,

Ellicott City, Maryland.

The diagnosis of congenital imbecility is not a very difficult one to the general practitioner, or even the trained nurse, for the earmarks of the mental deficiency are very often supplemented by physical disproportions, or are shown by some lack of the points we expect to find in a normal child; a something not at all easy to define, but none the less apparent. When a normal child is delivered there is nothing in its appearance to divert our attention, but when the abnormal one makes its appearance there is an undefinable sense of something missing, though just what this something is would be hard to say.

The elder Seguin once told me that an imbecile child never had the creases in the palm of the hand that the normal child was sure to have; this is a point for the obstetricians. I have never been able to verify the fact from lack of sufficient experience. A large sized head is a tempting point of diagnosis, but it is difficult to judge always whether the apparent over-size is due to an involuntary comparison with an under-sized body or whether the deformity is due to some transitory cause that nature is amply able to overcome. A very small skull is rather stronger evidence of abnormality, and if there is some distortion in the shape, as for instance the head flattened anteriorly or posteriorly, at the sides or on top, if the head is cone-shaped, balloon-shape, with the swell of the skull overshadowing a small wizened face, or if there is a marked disproportion between the lateral, or the anterior or posterior halves of the skull, it may be assumed that we have to deal with some form of congenital mental deficiency.

The mother sees the first true indications of abnormality; her baby does not rest in her arms as the normal child does; the head hangs back, rolls on the pillow automatically, the eyes are unlighted and play in their sockets like a pendulum, or are fixed to one side or the other. There is a difficulty in the act of suckling, or a difficulty in swallowing the milk once drawn into the mouth; there is absence of voice, or instead of the soft sounds of the baby's cooings, there are sounds more akin to those of animals; the spine refuses to do its duty, the legs sprawl, the hands are closed, thumbs drawn inward, but have no power of grasping, or pointing. Later, profuse salivation, imperfect sensations and disordered movements appear more de-

finitely emphasized; if from some trivial cause convulsions or coma sets in, the condition of the child is more serious than is usual and if it recovers from the attack its mental condition is worse, being left in a lower grade than the attack found it.

Still later we begin to see other and more marked differences; the normal child now begins to use its hands, the other allows his to remain in a state of flexion; the one will move his hand at will, the other will toss his about aimlessly; the look of the one is straightforward and intelligent, that of the other has no object in its restless glance from side to side, wandering from object to object, without purpose, having seeing eyes yet not seeing.

The one sits erect, and meets its friends with a smile in ready response to encouragement; the other remains supine wherever left and no sign of recognition relieves the dull monotony of its expression. Each day deepens the impression of something lacking; compared with children of his age this poor unfortunate seems to go backward instead of forward; the functions of organic life are below the normal standard, the respiration is shallow, the pulse is not resistant, the appetite is abnormal in regard to quantity or limited to a desire for some few things; the act of eating is animal-like, the food is not properly masticated, attributable to absence of intelligence, want of will power to act on the organs of mastication and deglutition or deformity and want of relation between the same; there are perversions of the functions of animal life, or diminution or suppressions of the same. The imperfections of locomotion, the inability to grasp to whatever degree it exists, marks the limit of the isolation of the idiot; he cannot go to anything, he cannot come into active possession of objects within his reach because of his uncertain grasp; he is a prisoner shackled by his muscular deficiency; he may have the necessary motor functions but they are beyond the control of his will, and produce desultory movements that from their want of harmony prevent accomplishment. He may expend his muscular force in spasmodic motion, a condition analogous to chorea or epilepsy, or what is more frequent, waste his efforts in automatic movements; of these, the automatic dissipation of contractile force is the most positive in its impressions upon the general system, years of training being necessary to overcome the results of a few years of indulgence.

Aberrations of the special senses are frequent and irregular in their expressions. As a rule, the mental defective shows a striking dullness of touch ; the hands and fingers are imperfectly controlled by the will and lack the sensibility of the normal hand and fingers ; this is true of the general surface ; pain, as pain, seems to be an unknown quantity ; it is not unusual to see such children undergo quite painful operations without a murmur. On the other hand, there are cases in which the sense is highly exalted, the child suffering agonies from contact with the softest objects. It has been pointed out that these cases are dulled by cold weather, undergoing a sort of mental hibernation ; this may be true, but there are cases seen who apparently see no difference in either cold or hot weather, needing the most constant oversight to keep them properly clothed ; enough in winter and not too much in summer. In our school-children, if they are kept at a reasonably warm temperature, say 65° Fahrenheit, show very little difference, if any, in their mental improvement during the cold months ; in fact it seems to need more of an expenditure of force on the part of the teacher to claim their attention during the heated term than at any other time of the year.

Taste and smell are sometimes abnormal in their expressions ; the child may substitute the one sense for the other, or to all appearances both senses seem to be dead ; the usual errors are that the smell is exaggerated and taste deteriorated.

With hearing as with seeing, we may find a like condition of hearing ears without the co-ordinating power that will enable the child to appreciate the sounds that vibrate on its tympanum ; possessed of perfect organs of audition,

he is practically deaf. There are interesting phenomena connected with this intellectual deafness; for instance, the child may hear sounds that please it, but no others; he may hear music and not voices; he may retain tunes and repeat them, yet be unable to hear or repeat a single word; he may be actually insensible to sound; he does not want to hear; the exertion of responding to the auditory impression is too great to overcome, and he will not try to overcome his own inertia; this same trait is shown in seeing and in speech.

In some cases the repugnance to look is something impossible to overcome and militates against improvement; in other respects the child can see, but the figures passing over his retina are like the shadows on the smooth surface of a river, and the passing impressions are not permanent enough to serve as educational forces.

Speech is lacking in some instances from an inability to acquire a vocabulary and utilize the innate ability to speak; or they may have a limited command of words but still be unable to use them; as expressed by Seguin, "Mere speech is only the function, language the faculty." Excluding organic disorders of speech, functional mutism may be due first to direct incapacity of the will to move the organs of speech; second, confirmation of the habit by indulgence; third, lack of desire to speak, increased by the lack of understanding of the power of speech as a faculty.

Thus rapidly we have run over some of the principal manifestations of imbecility, using the term to cover all mental defectives of whatever grade. In this connection it may not be out of place to give the divisions of this class of defectives as suggested by the late Dr. I. N. Kerlin, a series of groups that serve their purpose better than any suggested by other authorities—these go from the lower grades to the higher:

Idiocy, (*a*) apathetic, (*b*) excitable; idio-imbeciles; imbeciles, (*a*) low grade, (*b*) middle grade, (*c*) high grade; juvenal insanes.

It would be interesting to linger here for a time and speak more fully of each grade, but the limits of my paper will not permit, and I will now ask your attention to a consideration of the most frequent forms of disease as found in a community of the feeble-minded. A study of the statistics of any or all of the asylums of this and other countries show the alarming frequency of lung troubles; one writer says of eight hundred and twelve cases during the year forty per cent. were diseases of the lungs and air passages, twenty-one per cent. were referable to the gastro-intestinal tract, ten per cent. were skin diseases and only eight per cent. were diseases of the brain or nervous system, the remaining cases being divided between various medical and surgical cases. The death-rate during the year from which these figures were taken was exceptionally high, four per cent., as compared with one and seven-tenths per cent., of the year previous, and over fifty per cent. of the deaths were due to diseases of the lungs and air passages. Another gives a mortality of fifty per cent. from lung troubles during five years; it is worthy of note that during this period there was but one death from meningitis, no other fatal case of brain or cord disease being recorded.

An interesting query arises as to the reason why the supposedly defective organs should have such immunity from acute disease, while other organs not of necessity abnormal should suffer in such proportion. In epidemics of the eruptive diseases, the sequelæ are much more serious and of a more aggravated type; pneumonia, bronchitis, pleurisy, especially the former, almost always follow in the wake of such epidemics, and it is said that some form of eye trouble is also an additional and exceedingly troublesome sequela.

One peculiar feature of some cases is the facility with which they will dispose of articles of the most indigestible nature, yet suffer no evil results from the repast. I remember a boy at Elwyn who ate heartily of cracked hickory nuts, swallowing them shells and all, and though there was need of surgical assistance to unload his rectum, there was no further effect upon his general

health ; others will habitually swallow their food without masticating it properly and know nothing of dyspepsia ; others will use enormous quantities of tobacco without a symptom. It has been asserted that as a class these cases are less apt to be sick during the warm weather, but I have noticed in this climate that the cold waves of recent summers have been certain to provoke diarrhea and dysentery ; otherwise I believe the general statement correct.

Enuresis is of frequent occurrence among the lower grade ; Kerlin gives fifty-five per cent. as the average in asylum cases ; one-third he gives as being entirely due to low mental power, occurring every night ; in the remainder of the cases it happened once a week or at longer intervals.

In regard to physical development some very interesting conclusions have been reached. Dr. Tarbell, of the Massachusetts Institution, found on investigation that—

"1. Idiotic children were two inches shorter than normal children and nine pounds lighter, at the same age. 2. That the relative rate of growth of the two sexes of idiot children corresponds very nearly to that of normal children and is subject to the same variations at the age of puberty. 3. That the age of puberty is about two years later in idiots than in other children."

Dr. Shuttleworth says that the uniform physical inferiority is easily noticeable, "many are born small, not a few are premature births. British idiots are shorter than the general population, at five years by one inch, at ten by two inches, at fifteen by three inches, at twenty by three inches. As regards weight, male idiots are lighter than the general population, at eight years by four and one-half pounds, at ten by six pounds, at fifteen by eight pounds, at twenty by twenty-three pounds, the disparity being greater in the male than in the female. The relative rate of growth of the two sexes is about the same as that of normal children and is subject to the same variations at the age of puberty, for two years preceding which the growth of girls is in excess of boys."

I have been struck with the facility with which an imbecile will suddenly and without apparent cause drop several pounds off his weight and then pick it all up again as quickly as it disappeared.

Others again will have an appetite Gargantua-like, and so far as can be judged by close observation assimilate it all, yet remain thin and gaunt, while others will assume flesh with the most wonderful celerity, yet not eat enough to count on the increased weight.

Diagnosis of disease in the feeble-minded is attended with some difficulty in that we have little more than objective symptoms to guide us to a definite conclusion ; reflexes are not active and added to their inability to tell their aches and pains is the almost universal general anesthesia. It is not at all uncommon to have cases of phthisis without the cough or night-sweats ; fracture of bones may also occur without complaint ; now add to this the faculty some have for mimicking symptoms, and others again who maintain their serious illness without a symptom, yet insist upon treatment, and it will be seen that it is not an easy task to make other than a tentative diagnosis in many cases, until time brings out actual and distinctive signs of trouble.

The treatment of disease in these cases is just the same as that of any other case of the same nature. I have found that suggestion bears no little share in the treatment ; they soon recognize the doctor as a friend and will obey him implicitly if there is will power enough in the case to exert that far, and the doctor's mere say-so "you will soon be well" is many times as good as a dose of medicine.

In conclusion, let me invite your attention to some figures of importance in view of the paper read yesterday by Dr. Rohé, as additional arguments in favor of measures to control the ravages of phthisis and the far-reaching results of inebriety : Fifty-six per cent. of idiocy descends from strumous and consumptive families. Thirty-four per cent. of idiocy is descended from a history of alcoholism with cases of epilepsy, nervous disease and crime in the same inheritance.

If in twenty-five per cent. of idiocy there is maternal anxiety and over-tax sufficient to enter as a direct or accessory cause of the child's infirmity, is not this a strong argument for a better protection of the mother during the gestative period, from exhaustive duties and hyper-exaltation of the nerve centres, either in housework or frivolity?

If such an enormous percentage of this afflicted class as 56 per cent. are descended from parents of strumous or consumptive tendency, if so large a proportion of the inmates of our asylums for the feeble-minded as 34 per cent. have a history of alcoholism and nervous disease in their pedigree, are we, as conservators of the public welfare, demanding too much when we ask for some restrictive measures in regard to marriage between such tainted couples?

LARGE FIBROID TUMOR OF THE UTERUS.

Read Before the Chicago Gynecological Society, March 16, 1894.

By T. J. Watkins, M. D.,
Of Chicago.

Mrs. P., aged 35, had suffered for several months from continuous pain in the left inguinal region, extending down the left thigh. Examination revealed a hard mass to the left of the uterus, which was diagnosed as a fibroid of the uterus extending into the broad ligament.

After the usual preparatory treatment for operations in the vagina I operated on December 1, 1893, in the following manner: About an inch and a half of the vaginal wall was detached by an incision around the left half of the cervix. The connective tissue between the tumor and the vagina was easily separated by the finger. After incision of the capsule the tumor was enucleated. The peritoneal cavity was not opened. It was impossible to determine the amount of uterine wall external to the tumor.

The operation was attended by considerable hemorrhage, which was, however, readily controlled by packing with gauze. The gauze packing was removed on the third day. The patient made an uninterrupted recovery and left the hospital on the ninth day. The cavity rapidly diminished in size; and in two weeks the cicatrix was the only trace of the operation that remained. The tumor was spherical, two inches in diameter, and composed of dense fibrous tissue.

Little is to be found in the literature regarding uterine fibroids which extend in to the broad ligaments. Skene [1] describes them, but considers their treatment under that of fibroids in general. Vaginal section for the removal of fibroids receives scant mention in the literature. Pozzi [2] advises against vaginal operation for subperitonealfibroids. Martin[3] of Berlin, says: "In cases of cervical myomata . . not developed as subserous tumors into the floor of the pelvis. . extirpation is to be undertaken from the vagina." Stansbury Sutton[4] once divided the posterior wall of the vagina, and through the opening delivered a "supraperitoneal fibromyoma." He saw Martin, of Berlin, remove a small subserous tumor per vaginam, but does not state the location of the tumor or whether or not it was pedunculated. Sutton also says: "The tumors properly removed through the vagina are polypoid, submucous, and interstitial." Caselli [5] removed a subperitoneal fibroid of the cervix by splitting the vaginal wall which covered the tumor. Vander Veer [6] removed a fibroid tumor by opening into Douglass' pouch. Czerny[7] records three cases of removal of fibromata by vaginal section, with one death. Ohlshausen [8] removed a uterine fibroid by extraperitoneal enucleation through an opening made in the posterior vaginal wall. Gusserow [9] says: "In a general way it may be stated that this method is applicable only to small tumors which are situated outside of the cavity of the peritoneum. Growths so situated are, however, very apt to cause considerable disturbance." Lomer [1]

mentions a successful operation by Frankenhauser, and also one by Schröder, in which the tumor occupied the anterior wall of the uterus.

The case reported is the only one of fibroid extending into the broad ligament which has come under my observation. I believe that vaginal section is applicable to the removal of many small subperitoneal fibroids of the cervix uteri, in the enucleation of which it would not be necessary to enter the peritoneal cavity. In case of severe hemorrhage the uterine arteries could be ligated according to the method recently described and practiced by Martin.[11]

This communication is made, not for the purpose of recording a unique operation, but to elicit discussion on uterine fibroids extending into the broad ligament, and on the applicability of vaginal section for the removal of subperitoneal fibroids of the cervix uteri.

REFERENCES.

1 Skene.
2 Pozzi: Med. and Surg. Gynec., vol. i., p. 271.
3 Martin: Diseases of Women, p. 277.
4 Sutton: Am. System of Gynec., vol. ii., p. 577.
5 Caselli: Annuali di Obs., 1881.
6 Vander Veer: Boston Med. and Surg. Jour., 1879.
7 Czerny: Wiener med. Wochenschrift, 1881, Nos. 18 to 19.
8 Olshausen: Klin. Beitr. z. Gynakol. Geburtsk., Stuttg., 1884, p. 96.
9 Gusserow: Cyclopedia of Obs. and Gynecol., vol. ix. p. 261.
10 Lomer: Zeitschrift f. Geburtsk. u. Gynakol., vol. ix., p. 277.
11 Franklin H. Martin: American Journal of Obst., 1893 and 1894.

SOCIETY REPORTS.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND.

NINETY-SIXTH ANNUAL SESSION, HELD AT THE HALL OF THE FACULTY, BALTIMORE, APRIL 24 TO 27, 1894.

Dr. S. T. Earle, Chairman of the Committee on a Disinfecting Plant by Heat, reported that as the mayor differed radically with the committee as to the location of such a disinfecting plant, they had dropped the matter temporarily, but propose to renew the fight for such a plant.

Dr. P. C. Williams, of the Committee on the Union for Public Good, reported that that union had secured the passage of the anti-sweating law, and it is now considering the matter of child labor, and the passage of a compulsory education law as an auxiliary to preventing child labor in the State.

Dr. Tiffany stated that the present location of the faculty's room was very undesirable; that it was very cold in winter, and that the books were injured from dampness. A committee was directed to consider the feasibility of engaging more suitable apartments.

An invitation was received from the physicians of Cumberland, inviting the faculty to hold its next convention in that city.

Dr. Tiffany moved for a revision of fees, which was ordered to be made in thirty days.

Dr. T. A. Ashby offered a resolution, and it was adopted, providing that as the centennial of the Medical and Chirurgical Faculty of Maryland occurred on June 20, 1899, therefore a committee be appointed to provide for a centennial celebration in a proper manner.

On motion of *Dr. M. B. Billingslea* a standing committee will be appointed to urge municipal, State and national legislation in the interest of public health and the medical profession.

The election of officers and appointment of committees resulted as follows: President, Robert W. Johnson; Vice-Presidents, Charles W. Jones and W. M. Nihiser, of Keedysville; Recording Secretary, Joseph T. Smith; Assistant Recording Secretary, Robert T. Wilson; Corresponding Secretary, James M. Craighill; Reporting Secretary, W. Guy Townsend; Treasurer, W. F. A. Kemp; Executive Committee, George H. Rohé, William H. Welch, L. McLane Tiffany and David Streett; Examining Board, Western Shore, S. T. Earle, G. Lane Taneyhill, A. Friedenwald, R. H. P. Ellis, Wm. E. Moseley, P. C. Williams and Hiram Woods, Jr.; Examining Board, Eastern Shore, W. F. Hines, B. W. Goldsborough, Monmonier Rowe, G. E. Dickinson and James Bordley.

Library Committee—B. B. Browne, G. J. Preston, W. Osler, S. K. Merrick and C. W. Mitchell.

Publication Committee—J. T. Smith,

W. F. A. Kemp, J. W. Chambers, D. Streett and M. B. Billingslea.

Memoir Committee—E. F. Cordell, A. J. Dalrymple, D. W. Cathell, E. Anderson and G. E. Dickinson.

Committee on Ethics—P. C. Williams, T. S. Latimer, J. E. Michael, R. H. Goldsmith and C. R. Ellis.

Committee on Progamme—W. H. Welch, T. A. Ashby, H. Friedenwald, I. E. Atkinson and M. A. R. F. Carr.

Curator—W. T. Howard, Jr.

State Licensing Board—James Bordley, President; W. F. Hines, J. McP. Scott, F. B. Smith, W. W. Wiley, J. L. Ingle, and W. F. Lockwood, Secretary.

Committee on Public Good—P. C. Williams, A. K. Bond and W. J. Todd.

Membership Committee—T. A. Ashby, A. Friedenwald, J. S. Fulton, R. P. Smith and A. S. Porter.

Committee on Disinfection by Heat—S. T. Earle, J. C. Hemmeter, S. A. Keene, A. S. Powell and R. C. Rasin.

Committee on Legislation—S. T. Earle, W. H. Welch, T. P. McCormick, J. W. Jamar, W. F. Hines, C. O'Donovan, T. W. Simmons, E. C. Etchison, C. G. W. Macgill, A. Friedenwald, I. E. Atkinson, J. Piper, F. D. Sanger and J. B. Hart.

Committee on Preventable Blindness—H. Woods, Jr., H. Friedenwald, J. F. McShane, L. E. Neale and W. Brinton.

Committee on Centennial of the Faculty—T. A. Ashby, J. F. Monmonier, E. F. Cordell and C. H. Ohr.

Committee on Permanent Location—L. McLane Tiffany, B. B. Browne, H. P. C. Wilson, J. J. Chisolm, G. W. Miltenberger, G. L. Taneyhill, W. H. Welch, W. Brinton, T. A. Ashby, A. Friedenwald, G. J. Preston, D. W. Cathell, H. Woods, Jr., W. Osler and H. M. Wilson.

Committee on Revision of the Fee Table—D. W. Cathell, I. E. Atkinson, T. A. Ashby, S. Theobald, G. J. Preston, J. Neff and R. Winslow.

The following were elected members of the faculty:

Active—Drs. E. L. Beckley, Claribel Cone, Garland Hamner Davidson, Sheldon G. Evans, Thos. C. Gilchrist, James L. Ridgley, Joseph C. Wunder, J. W. P. Bates, Charles Henry Bennum, J. C. Bloodgood, Joseph Clement Clarke, L. E. Conradi, Milton R. Walter, Peter J. Doran, Charles Getz, F. C. Jewett, Sylvan Likes, E. A. Munoz, Standish McCleary, Charles W. McElfresh, Wm. J. Pillsbury, Flora Pollack, James Marshall Price, Melvin Rosenthal, J. M. H. Rowland, J. Hugh Stier, A. W. Thompson, Eugene McEvers Van Ness, Frank E. Wagner, Elijah Williams, Wm. P. E. Wyse, J. H. M. Bateman, John W. Hocking and J. M. B. Rogers.

Honorary—Drs. James T. Whittaker, of Cincinnati, and Henry Newell Martin, of Cambridge, England.

Among those registered were Drs. W. E. Jones, N. H.; G. E. Day, Darlington, Md.; S. V. Mace, Rossville, Md.; V. de Murgiuondo, Petersburg, Va.; J. Percy Wade, Catonsville, Md.; Edward A. Scott, Galena, Md.; S. B. Muncaster, Washington, D. C.; P. Chapman, Perrymans, Md., E. J. Sprathing, Opelita, Ala.; H. G. Martinique, Buffalo, N. Y.; J. M. B. Rogers, Clarkville, Md.; S. D. Kennedy, Annapolis, Md., B. R. Benson, Cockeysville, Md.; Monmonier Rowe, Deal's Island, Md.; J. H. Jamar, Elkton, Md.; L. Gibbons Smart, Towson, Md.; J. L. Ridgeley, Rockdale, Md.; G. E. Dickinson, Upper Fairmount, Md.; J. E. Benson, Cockeysville, Md.; E. T. Scott, Galena, Md.; W. H. Marsh, Solomon's Island, Md.; W. M. Nihiser, Keedysville, Md.; W. F. Elgin, Bethesda, Md.; Frank H. Ruhl, Landsdowne, Md.; G. C. McCormick, Sparrow's Point, Md.

The Marriage of Syphilitics.—In general the advice to syphilitics would be not to marry, but Dr. William G. Porter believes in doing the syphilitic justice, and for this reason he looks at the subject with very lenient eyes. He divides the disease into the benignant, the moderate and the malignant variety. The stages explain themselves. The first form recovers with no treatment, while the second and third need a skillful physician's advice, and after all disappearance of the symptoms the patient may safely marry in two years. Other authors do not give such a short time as this.

MEDICAL PROGRESS.

POISONING BY ILLUMINATING GAS.—The various jokes on the countryman who blows out the gas shows to what an extent this accident occurs and that it is not often done intentionally is the opinion of Dr. John W. Shaw, of Washington, D. C. (*Virginia Medical Monthly*), who believes that 94 or 95 per cent. of cases are due to either carelessness, ignorance or accident.

His theory is that the gas poisons in three different ways. First. By the gas replacing, to a greater or less extent, the atmospheric air, consequently reducing the supply of oxygen. Second. By the direct poisonous properties of the heavy and light carburetted-hydrogen, when mixed with air and absorbed through the lungs. Third. By the collection of carbon dioxide in the body for the want of sufficient interchange of gases necessary to remove it. He thinks that it is the retention of effete material in the system that does the harm and it is as much the carbonic acid gas as the illuminating gas which cripples the blood corpuscles which are not able to carry off the carbonic acid gas, thus overwhelming the respiratory centres and causing death.

He does not believe in the use of oxygen but thinks that transfusion of blood would be the most rational form of treatment in extreme cases, for it immediately supplies the system with the hemoglobin, of which it is in such great need. This, combined with fresh air, artificial respiration, heat, and stimulants, are sufficient to keep one busy until life or death removes the responsibility.

As a stimulant he prefers hypodermic injections of nitro-glycerine as recommended by Kloman, to ammonia by the rectum.

* * *

PRIMARY NASAL DIPHTHERIA.—Nasal diphtheria is a severe and fatal disease and is usually secondary to the disease in the throat, but Dr. Charles W. Townsend has reported in the *Boston Medical and Surgical Journal* fourteen cases, in which seven were nasal and five of these were primary. These cases are easily overlooked but not easy to diagnose; indeed the diagnosis is not certain without a bacteriological examination, and for this reason such cases are dangerous, for they go about unsuspected and even after they are convalescent the nasal mucous membrane harbors the bacilli for a long time. The sources of these cases of diphtheria were not difficult as they had mingled with each other at different times and the habit of picking the nose must furnish an easy method of infection.

The following points in this paper seem to be of interest.

(1) The fact that primary nasal diphtheria may occur of a very mild type.

(2) The dangerous character of these cases, as they are likely to go unrecognized for the following reasons:

(*a*) The resemblance of these cases to ordinary coryzas, a membrane not being noticed in some cases except by careful scrutiny.

(*b*) The normal or only slightly elevated temperature often present, with but little constitutional disturbance.

(*c*) The intermittent character of the nasal discharge, absent for several days, and then starting up again.

(*d*) The apparent recovery, even with cessation of nasal discharge, while Klebs-Löffler bacilli are still present.

(*e*) The fact that these bacilli have not lost their virulence; or, in other words, the fact that the patient having the bacilli in his nose, although apparently well, may transmit the disease in a fatal form to others.

(*f*) The difficulty of always finding the bacilli in the nose, even when they are present.

(3) The importance of bacteriological examinations in all suspicious cases of nasal discharge.

(4) The importance of prolonged isolation, together with a refusal to consider a case cured until *several* consecutive negative cultures have been obtained.

* * *

NERVOUS EFFECTS OF DIGESTIVE DISORDERS.—Among the obscure problems in medicine is a relation of some of the nervous effects of digestive disorders which Dr. A. K. Bond, in the *Virginia*

Medical Monthly, believes will become clearer as we advance in our knowledge of medicine. He believes that there is a group of disturbances, in the sexual, mental, motor and sensory departments of the nervous system, which are due to ofttimes obscure, sometimes unsuspected, disorders of digestion and of the assimilation of digestive products; and that these often perilous disturbances, though temporarily soothed by opiates and other anodynes, require for permanent cure the thorough cleansing and restoration to normal function of the digestive tract.

* * *

Pelvic Disease and Insanity.—Dr. Charles C. Fowler (*University Medical Magazine*), in following in the footsteps of Dr. George H. Rohé, draws the following conclusions from his study of these cases from a gynecologist's point of view.

(1). If a pelvic lesion is responsible for certain mental or nervous symptoms, the said symptoms, so long as the exciting cause remains active, will steadily grow worse, until they eventually become more formidable than the initial disease, and cannot be cured by any known surgical procedure.

(2). That we should never, scientifically speaking, wait for remote effects before we relieve pelvic disease.

(3). That if women, after they reach asylums, are cured by surgical means, it is the duty of the gynecologist to see that they never go there.

* * *

Laminectomy for Fracture of the Spine.—Giles reports in the *British Medical Journal* an unsuccessful case of laminectomy for fracture of the seventh and eighth dorsal vertebræ. The operation was performed on the tenth day from the date of injury. The patient—a man, aged 42—improved at first, but on the ninth day after the date of the operation became delirious. He lingered until the thirty-fourth day, when he died from exhaustion, the delirium having persisted, and bed sores having formed and become very deep and extensive. This case, the author thinks, was one well suited for the operation, if laminectomy is ever to be performed for the relief of fractured spine. If the original injury—a fall on to the back from a height of about 14 feet—had not caused such a severe concussion that the functions of the cord were permanently abolished, a different result, it is believed, might have been obtained. The cord was not crushed or lacerated; there was no intradural hemorrhage or inflammatory sequelæ; there was no displacement of the bodies of the fractured vertebræ; and the only alteration in the normal lumen of the spinal canal was caused by depressed laminæ, which were removed at the operation.

* * *

Scurvy in Infants.—Scurvy is supposed to be a rather uncommon disease in infants in this country, but Drs. W. P. Northrup and F. M. Crandall (*New York Medical Journal*) began to collect histories of cases and found that the disease occurred more frequently than it was supposed. They reported eleven cases in 1891. The gums were large and spongy; the thighs were abnormally large; there were superiosteal hemorrhages, chiefly in the long bones. The diagnosis probably rests on the hemorrhage symptoms.

Of 114 cases collected, a detailed history of 32 was obtained, and of these 16 were males, and 16 females; the youngest was four months and the oldest was an idiot of six years. The disease seems to be most common at about the end of the first year. Twenty-six were seen in private practice and ten in institutions; in fourteen the surroundings were excellent, rich or luxurious; in two bad, and in five very bad. Ten of these children lived in the country and the disease seems to have no connection with unhygienic conditions.

The exclusive use of a proprietary food or of evaporated milk was the most common cause. Anemia was present in fifteen cases, rickets in nineteen, diarrhea in six, constipation in two. There was fever, pain and pseudo-paralysis in some; there was passage of blood from the bowels, and there was subcutaneous hemorrhage in the form of purpura, petechiæ or ecchymoses in fifteen cases; there was swelling of the extremities in

thirty-three cases. The results of the antiscorbutic treatment were most brilliant. General tonics, acids, phosphorus, or chlorate of potash were given with little effect, but the antiscorbutic diet did the greatest good. The conclusions drawn by the authors are:

1. Scurvy may appear at any period of infancy or early childhood, but is most common between the ninth and fourteenth months.

2. The lesions are hemorrhagic in character, due probably to diapedesis. The most characteristic are superiosteal hemorrhages. Hemorrhages into the muscular tissues, into the skin, and mucous membranes are more or less constant.

3. It occurs in every grade of social scale, but is more frequent among the rich than among the poor. The neglected child who eats everything at the table may become rhachitic or marasmic, but he obtains enough fresh food to protect him from scurvy. It very rarely occurs in asylums and hospitals, because in recent years feeding in such institutions has been more rational than in many private families.

4. Lack of fresh food is the most important cause. The use of the proprietary foods and condensed milk produces more scurvy than all other causes combined. Even fresh milk in small proportions is not sufficient to insure protection.

5. Anemia and malnutrition are almost invariably present; a peculiar sallow complexion is common.

6. Scurvy is frequently superadded to rhachitis, but in a considerable number of cases no evidences of rhachitis are present. So-called acute rickets is in most cases, probably in all, rickets complicated by scurvy.

7. Pain is a constant symptom ; it develops early and is usually intense.

8. A varying degree of immobility of the extremities is common, and is frequently so marked as to simulate paralysis. This pseudo-paralysis disappears with the subsidence of the scorbutic symptoms.

9. Subcutaneous hemorrhages, as well as hemorrhages from the cavities of the body, are very common, but are not necessary to a diagnosis of scurvy.

10. The condition of the gums is characteristic. They are purplish, soft, spongy, and bleeding, and frequently show decided ulcerations. When the teeth have not been erupted, changes in the gums are usually slight or entirely absent.

11. Painful swelling of the lower extremities is the most constant symptom ; the upper extremities are rarely involved. The thigh is affected more frequently than any other region.

12. Children suffering from scurvy commonly present the following symptoms : Anemia, intense pain on motion, spongy and bleeding gums, swelling of the lower extremities, usually at the thigh. There may also be purpura or ecchymoses, discharge of blood from the various cavities of the body, and pseudo-paralysis.

13. Scurvy, when untreated, is a very fatal disease ; when recognized and properly treated, a rapid and complete cure is usually effected. The result of antiscorbutic treatment is, in fact, one of the most certain means of diagnosis.

14. Scurvy may be mistaken for rheumatism, stomatitis, rickets, sarcoma, osteitis, and infantile paralysis.

15. Scurvy is a dietetic disease and must be cured by dietetic treatment. Fresh milk, beef juice, and orange juice are the most effective.

* * *

Poisoning by Benzine.—Rosenthal reports in the *British Medical Journal* a case in a girl aged 1½ years. The quantity taken was uncertain. When seen, ten to fifteen minutes afterwards, the child was in a condition of stupor, with half-open eyes. The radial pulse was small, frequent, and subsequently could not be felt. Respiration 60 to 70. A tube was passed through the nose and the stomach washed out. The water used for the washing smelt strongly of benzine and contained blood-stained masses of mucus. In about six hours the child had considerably improved, and subsequently recovered completely. Benzine produces a gastro-enteritis, as, indeed, it has been shown to do in ani-

mals. Treatment should consist in washing out the stomach as soon as possible, as benzine is rapidly absorbed. If the breathing fails artificial respiration should be practiced. Benzine is not identical with benzol, but is a mixture of hydrocarbons, especially hexan and heptan. Sometimes benzine poisoning is caused by inhalation. The author refers to a case of an alcoholic who took to inhaling benzine in place of drinking. He also refers to some instances in glove cleaners, and observes that this fact should not be overlooked in such cases.

* * *

Trephining in Gun-shot Wounds of the Cranium.—Quénu advocates (*British Medical Journal*) preventive trephining in cases of gun-shot wound of the cranium, holding that subsequent mischief is always the result of infection. Trephining in itself is quite free from danger, and it would be useless and dangerous to refrain from this operation until after the appearance of meningo-encephalitis. It is possible that bullets are aseptic, but there is no proof of this, and certainly the fragments of clothing and the hairs which they traverse and carry with them are not so. At a recent meeting of the Société de Chirurgie, Quénu reported three cases of gun-shot wound of the head treated by trephining. In the first case the operation was not performed before the end of the third week, when pus had collected under the dura, at the seat of injury. A fragment of lead was removed from the brain, and the suppurating cavity was drained. The patient, it was thought, had recovered, but six weeks after the operation he died in an attack of epileptiform convulsions. The second case, which was one of suicidal injury of the cranium by a revolver, was also treated expectantly, but on the fourth day, as the patient complained much of headache, the author enlarged the external wound, trephined the skull, and exposed five balls—two fixed in the bone, two lying on the dura, and the fifth embedded in the brain. The subject of this case recovered. The third was a case of penetrating gun-shot wound of the forehead. Notwithstanding the absence of bad symptoms, Quénu opened the skull and incised the dura. No bullet was found, but as there was a second wound at the back of the head, it was concluded that it had made its exit. This patient also recovered. Quénu holds that in cases of this kind it is advisable to explore without delay, and to render the seat of injury aseptic by trephining. The surgeon is thus enabled to extract the projectile, and any fragments of bone, together with hair and clothing. As bad results can be thus prevented, abstention in cases of penetrating gun-shot wound of the head would be regarded by Quénu as faulty practice.

* * *

Tumor Affecting the Restiform Body.—A case of an interesting and uncommon character published in full in the *Progrès Médical* by Brissaud is reported in the *Lancet*. The patient was a woman of forty-five who had no personal or hereditary history of significance. In 1885 she began to suffer from a slowly developing deafness of the left ear, and a year later the sight of both eyes was affected. *Tic convulsif* of the left side of the face was soon superadded and five years from the commencement of the symptoms pain over sacrum, weakness of the legs, with stiffness and pain in the cervical region, were experienced. In the same year loss of smell came on. Since 1893 intense headaches, starting in the neck and occurring especially in the morning, were very troublesome and frequent. In July of that year there was transitory œdema of the legs, and in the following month difficulty and unsteadiness in walking. In October there was an attack of loss of consciousness lasting an hour, and retraction of the head and opisthotonos were frequently present. The reflexes were not affected, and the upper extremities were normal. Optic neuritis was present on both sides, and difficulty in swallowing occurred. A diagnosis was made of tumor in the neighborhood of the corpus restiforme, and this was confirmed by the necropsy. The tumor involved the cerebellum, but had apparently commenced in the upper and outer part of the restiform body, and had involved the auditory nerve at its exit from the skull.

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See also Publishers' Department, Page 138.

BALTIMORE, JUNE 2, 1894.

The Treatment of Diabetes.

LITERATURE is not wanting in the number of drugs recommended to cure or ameliorate the symptoms of diabetes, but experience shows that so many of these are altogether inert or injurious. Dr. S. Solis-Cohen, in a clinical lecture in the *Therapeutic Gazette*, gives some very sensible hints as to the treatment of this disease and they appeal more to the patient himself than the usual directions as laid down in the text-books. He does not put too much faith in drugs; first of all, he advises keeping the urine alkaline and examining it frequently to note each day the variation in the amount of sugar ; and never to let the patient become constipated.

In common with many others, he recommends codeine as the best alkaloid of opium, being more effective without the unpleasant accompaniments of opium. A very good prescription is codeine combined with dilute phosphoric acid and hydrogen dioxide, which seems to increase the oxidation of the sugar. As for diet, he very sensibly advises against cutting off bread in every form and in this way shows that he has had practical experience with such patients, for if there is one thing difficult to do it is to cut off all starchy foods with no exceptions. The patient sooner or later will object and will either seek another physician who is more lenient or will privately take too much starchy food and deceive the physician and hurt himself. Let the patient have bread occasionally and even now and then a potato. No one can stand a strict non-starchy diet. What is gained in the absence of sugar is lost in flesh and in the disgust and want of appetite which follow, as the same food day by day palls on the palate. One good way is gradually to cut off one article after another, meanwhile examining the urine until a point is reached where the patient objects and the sugar is greatly decreased; then allow a little fredom in diet and give some of the prohibited articles again. In the end, even if the patient is not cured, the best and most satisfactory results will have been obtained. Above all things, do not pin the faith to drugs in general and especially to the new specifics, which profess to cure without fail. Dr. Solis-Cohen's concluding words of advice are:

1. Keep your patients warm and protected; cold is their greatest enemy.

2. Examine the urine for organic acids and keep the blood alkaline.

3. In the matter of diet, be strict enough to diminish polyuria and glycosuria, and, if possible, to secure their disappearance, *provided* you can at the same time keep the patient comfortable; but under any circumstances *make the patient comfortable.*

* * *

Modern Therapeutics.

THE resources of the coal-tar derivatives seem to be well nigh inexhaustible if the numerous reports of chemists and pharmacists are to be believed. No sooner does one remedy, which at the present day is either an antipyretic or analgesic, make its appearance on the horizon than another quickly follows, until the physician, anxious to heal, is bewildered and confused, and turns in despair and generally with relief to the old remedies which have stood the test of many years, and which do not vie with diamonds in their cost.

Of course, the great object in the practice

of medicine is to heal, and if a certain drug has curative powers (and such new remedies are usually recommended for diseases difficult to treat), the patient will never hesitate at any price; but if polysyllabic chemical compounds with fanciful names, giving no clue to their composition, are no better than many of the new remedies which die almost before they are born and whose reputation is built upon the testimonials written in the laboratory by the manufacturers, then it is but natural that the physician should hesitate to prescribe them.

There will have to be a stop somewhere. All new remedies should be submitted to a board of uninterested men who would investigate each one, give it a thorough test and report on it, showing also its composition and method of preparation. Then, and then only, will the deserving remedies stand and the worthless ones sink to their proper level. Whether such a thing be practicable or not remains entirely with practicing physicians, upon whom alone responsibility rests in this matter.

It is only in hospital practice that therapeutic tests of drugs can be made with justice to the patient and to the drug and it is the energetic, conscientious and honest hospital physician to whom the profession must at present look for reliable reports of new remedies.

* * *

THE great value of any medical gathering lies in its discussions; the papers themselves may be considered as the exciting causes of these discussions. For this reason papers read at medical societies should not be long and if possible something should be left to the imagination and intelligence of the audience and the whole literature from the time of Hippocrates should not be quoted. It is just as well to take it for granted that the audience has also read and may possibly know some of the facts which are so carefully collected together in a lengthy paper. The discussion is usually free and spontaneous and often some careful and observing clinician will in five minutes demolish any fanciful theories of the man who draws his deductions from books alone. Discussions are the life of a society and when long papers tire, members hesitate to prolong the subject with further discussion, even of the most interesting kind. Also in papers that contain a careful relation of many cases there is so much that can be easily abridged it seems strange that the writers themselves do not recognize and appreciate this fact. A medical or other society that encourages long-winded papers with little discussion is doomed to an early death, but when short papers call forth discussion from members who have something important to present, then, and then only, is the true value of such an organization shown.

* * *

PHYSICIANS who expect to visit foreign countries to study, even for a short time, should have some idea of the language which they will have to use; indeed, a rather intimate knowledge of this language is necessary, for without it even the most intelligent will lose much of what he has travelled so far to acquire. It is so generally the custom now for physicians to "brush up" in Germany or France that they should bear in mind the necessity of understanding the language thoroughly; but to speak it well is almost impossible without a long sojourn in that country. By employing an intelligent reader the ear will soon become accustomed to the foreign sounds and words with their definitions will be gradually absorbed and the ability to understand a lecture acquired without the mental effort of translating. This, coupled with a judicious use of books on the language, will satisfactorily qualify one for work in the foreign hospitals.

* * *

THE Congress of American Physicians and Surgeons, which has just closed its third triennial session in Washington, was composed of men whose work stands high in the medical profession. The Congress embraced fourteen sections, which met separately in the mornings and held joint sessions in the afternoons and evenings. The result of the work of this large body will scarcely be felt for some time to come, and it will be many months before the transactions of the various sections will be issued; meanwhile abstracts of the proceedings of one or all of the sections will appear in the journals and those who were not so fortunate as to attend the deliberations will have an opportunity to read of the work accomplished and profit thereby.

* * *

THE *American Practitioner and News*, of Louisville, speaks deprecatingly of the rapidly increasing disproportion between the number of doctors in that city and the inhabitants thereof—the ratio being about 1 to 333. The responsibility of the situation is laid at the door of the four medical colleges.

MEDICAL ITEMS.

There is said to be a strike of wet-nurses in Austria.

*

The J. B. Lippincott Company announce a work on Aseptic Surgery by Dr. Hunter Robb, of Baltimore.

*

Dr. John Morris has left for San Francisco to attend the meeting of the American Medical Association.

*

It is stated that the pecuniary loss from consumption alone in England, for every million children born, is $72,497.

*

Twenty-two nurses took their degree at the commencement of the Johns Hopkins Hospital Training School this week.

*

Among those who will receive the degree of Ph. D. at the Johns Hopkins University Commencement, is Dr. Christopher Johnston.

*

A justice in Brooklyn has ruled that compulsory vaccination is illegal and the Health officer of that city will contest his posttion in court.

*

The new home for epileptics at Port Deposit will probably open to receive patients about July 1. It will be called the Silver Cross House for Epileptics.

*

At the National Conference of Charities and Corrections asembled at Nashville, Tennesee, Dr. Edward N. Brush of the Sheppard Asylum read a paper on "The Treatment of the Insane."

*

Dr. S. Griffith Davis has resigned his position as resident physician at the Good Samaritan Hospital and has opened an office in the house formerly occupied by Dr. William Lee, corner of Eutaw and Hoffman Streets.

*

The proportion of Baltimore physicians who belong to or who attend national medical societies is remarkably small, as is noticed by comparing the membership of the American Medical Association from Baltimore and from Washington, a city one-half as large as Baltimore. There are 96 from Washington and 34 from Baltimore, and about the same proportion holds in the Congress of American Physicians and Surgeons.

Dr. F. C. Bressler is Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, and not Professor of Diseases of the Stomach, as stated in a recent issue of the JOURNAL.

*

According to the last census, of a total population in the United States of 62,622,250, almost three-fifths are single, a little more than one-third married and not quite one-twentieth widowed. More than half the population are males. There are three times as many widows as widowers, which would show that the latter remarry to a greater extent than the widows.

*

The recent Legislature of Maryland passed an act to erect a $75,000 insane asylum for the better care of the insane of the State. Dr. William Lee, secretary and executive officer of the State lunacy commission, recommends an increase in the number of attendants at Belleview Asylum. The county commissioners have in contemplation the erection of an addition to this institution for the care of the violently insane. Dr. Lee advises them not to make the expenditure on the ground that it is unwise and impracticable for any county to attempt the care of the insane.

*

A number of colored physicians of Baltimore have decided to organize and open a hospital and dispensary. A building has been secured and in a few weeks the work will begin. Dr. R. M. Hall is dean; Dr. W. T. Carr, secretary; other co-operators are Drs. J. O. Creditt, W. E. Harris, J. Marcus Cargill, C. H. Fowler, W. H. Thompson and L. D. Dyer. These men are all educated and stand well in their profession. Baltimore has a colored population of about 75,000 which are quite enough to support a colored hospital and the fifteen or twenty colored physicians in the city.

*

In an address recently issued by the Maryland State Board of Health, the importance of vaccination is urged as follows: "A general vaccination affords complete protection from small-pox for several years, often for life, and partial protection always through life. It seems like doubting the intelligence of the people of Maryland to present to them proofs of the protective power of vaccination. The long immunity from this disease which we have enjoyed has begotten a disregard of this unrivalled means of safety, and possibly, in some minds, ignorance of its value."

FEE TABLE.

The Medical and Chirugical Faculty adopted for its members, through the Committee on Revision of the Fee Table, the following:

MEDICAL PRACTICE.

First visit in any case of sickness	$ 2 to	$ 5
Each subsequent visit	2 to	5
First consultation visit	5 to	20
Each subsequent consultation visit	2 to	10
Single visit and advice in special cases where the physician is not the regular attendant	5 to	10
Distant visits, for every mile over two miles in addition to usual charge (night visits double), mileage	1 to	3
Night visits (between 10 P. M. and 7 A. M.	5 to	10
Detention with patient all night	10 to	50
In case of several patients in one family charge the visit to one, and to the others, each one-half the amount charged to the first.		
Advice at physician's office (night double)	1 to	10
Advice anywhere except at office	1 to	10

SURGICAL PRACTICE.

Amputation of large limbs	$100 to	$1000
" " toes or fingers	10 to	100
" through tarsal or metatarsal, and carpal or metacarpal bones	25 to	150
Amputation of penis	25 to	100
Resection of excision of large joints	100 to	500
Reduction of dislocations	10 to	250
Treatment of fracture of bones	10 to	500
Tenotomy	10 to	100
Important operations on the eye	50 to	1000
Minor " "	10 to	50
Extirpation of tumor	10 to	1000
" testicle	50 to	100
Using stomach pump, in case of poisoning	10 to	100
Excising tonsils or uvula	10 to	50
Dressing recent wounds	2 to	10
Each subsequent dressing, in addition to visit	2 to	5
Tying large arteries	25 to	100
Paracentesis	25 to	150
Tracheotomy	25 to	200
Lithotomy or lithotripsy	100 to	500
Introduction of catheter or bougie	5 to	25
Vaccination	2 to	5
Reduction of hernia (by taxis)	25 to	100
Operation for strangulated hernia	50 to	500
Intubation	25 to	100
Venesection	10 to	25
Laparotomy	100 to	1000
Curetting the Uterus	25 to	150
Plastic operation	50 to	250
Trephining	50 to	250
Operation for hare lip	50 to	150
" Aneurism	50 to	1000
" Necrosis or exostosis	50 to	250
Operation for Hydrocele	$ 10 to	$ 50
" Hemorrhoids	25 to	250
" Imperforate anus or vagina	25 to	250
" Fistula in ano or perineo	25 to	100
" Recto-vaginal or vesico-vaginal fistula	50 to	500
" Phimosis or paraphimosis	5 to	20
" Stricture of urethra	50 to	250
Evulsion of nail on toe or finger	5 to	25
Opening abscess	2 to	10

OBSTETRICAL PRACTICE.

Ordinary case of midwifery	20 to	100
Preternatural "	50 to	250
Extracting placenta alone	10 to	25
Miscarriage (same as ordinary case of midwifery)	20 to	100
Examination, per vagina	5 to	10

MISCELLANEOUS.

Microscopical or chemical examination of blood, sputum, urine or other secretion	5 to	50
Administering anesthetic	5 to	10
Written opinion as to health of patient	5 to	25
Oral opinion as to health of patient	5 to	10
Opinion involving a question of law	50 to	150
Examination for life insurance	2 to	10
Family physician's certificate for life insurance	5 to	10
Certificate of cause of death for life insurance		10
Post-mortem examination for legal investigation	100 to	200
Post-mortem examination for the family	25 to	50
Application of electricity	3 to	5
Extirpation of mammary gland	50 to	100
Gonorrhea or syphilis (in advance)	50 to	150

All services not herein specified to be rated in accordance with the above scale of charges.

I. The foregoing table contains the standard fees of the medical profession of Baltimore. All bills shall be rendered in conformity with the above fee table. They may be increased, according to the judgment of the practitioner concerned, in all cases of extraordinary detention or attendance; also in proportion to the importance of the case, the responsibility attached to it, and the services rendered, when these are extraordinary. They may be diminished at the discretion of the physician, when he believes the patient cannot afford to pay the regular fees and yet is able to make some compensation. It shall be considered, however, unprofessional to diminish the standard fees with a view to mercenary competition.

II. It is not designed by these regulations to prevent gratuitous service to those who are incapable of making remuneration without distressing themselves or families.

III. It is expressly enjoined on the members of the profession to decline all offers of a specific fee for attendance during any given period of time, as a measure unequal and often unjust in its action on one or the other of the parties, and as derogatory to the character and dignity of the medical profession.

IV. Every physician should present his account immediately after ceasing his attendance in any given attack of sickness, especially in all cases of surgery or midwifery.

V. It is desirable that consultation fees should be collected at each visit.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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NOTES.

THIOL is a good absorbent on most skin surfaces.

*

TOLYPYRIN is recommended when antipyrin fails.

*

SPASMOTIN (sphacelotoxin) is a poisonous element of ergot.

*

CHEWING gum combined with antiseptics is used in Germany.

*

DIGOTOXIN often causes the ill effects attributed to digitaline.

*

OXYSULPHURET of mercury is an excellent remedy in pneumonia.

*

PENTAL is recommended as a safe, quick and efficient anesthetic.

*

LYSOL combined with capsicum and iodine makes a very agreeable mouth wash.

*

MONOSULPHITE of soda in doses of eight grains a day is said to give rapid relief in lead colic.

*

LISTOL, a chemical compound of thymol and iodine, is said to be a perfect substitute for iodoform.

READING NOTICES.

DENVER, COLO., April 11, 1894.

Dios Chemical Co., St. Louis.—I have been using "Sennine" for the last month in all of my surgical cases and have had such excellent results with it that I feel like adding my word of approval to those which you have already received. I have used it in a great variety of cases; some of them have been of such a nature as to have put it to a very severe test, and in all of them it has given the very best of results. I have given almost all of the new antiseptics a trial but have never found any of them to be as serviceable as "Sennine." I have also found it a very valuable remedy in gonorrhea.—C. B. LYMAN, M. D., Ass't Surg., U. P. System.

*

Losophan.—Losophan is an effective combination of two of our most reliable antiseptics—iodine and cresol. As might be expected from its chemical composition, it is of especial therapeutic value in diseases due to the action of parasites, both animal and vegetable. In parasitic affections of the skin, Losophan is considered a specific by a number of authorities, among whom may be mentioned Saalfeld, Shoemaker and Descottes. In that very obstinate affection, trichophytosis barbæ (ringworm of the beard) it has effected a larger number of cures than any of the remedies ordinarily employed. Ringworm of the scalp and body yield rapidly to the action of Losophan, and good results have been reported from its use in scabies and pediculosis.

*

Antikamnia.—As an antiseptic, antipyretic and antiperiodic, Antikamnia is good, nothing better. It is especially beneficial in spasmodic asthenia, in hay fever, in whooping cough, in headaches, particularly of the nervous variety, also that from disorders of the digestive organs, or from the various neuroses. In mild hysteroid affections, in the various neuralgias, particularly ovarian, in the nervous tremor so often seen in confirmed drunkards, also in delirium tremens, it is of particular service. The pain of locomotor ataxia yields to treatment with Antikamnia in a remarkable degree, its analgesic power being of a peculiar kind, in that it will relieve painful affections due to pathological conditions of the peripheral nerves, as neuritis, etc.; also lumbago, sciatica and myalgia.

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ORIGINAL ARTICLES.

PRIMARY RESECTION OF THE INTESTINE FOR GANGRENE.

READ AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 24-27, 1894.

By J. W. Chambers, M. D.,

Of Baltimore.

RESECTION OF SMALL INTESTINE FOR GANGRENE. END-TO-END ANASTOMOSES WITH MURPHY BUTTON. RECOVERY.

CASE I.—Mrs. S., married, aged 38, had had a swelling in the left inguinal region for five years, which appeared while standing and disappeared when lying down; did not know what it was, and as it had never given her any special discomfort she thought but little of it. The tumor always had been returning when she took a recumbent position until twelve days before her admission into the City Hospital, on February 21, 1894. February 9, date of the occasion when she failed to return the tumor, the first signs of strangulated hernia made their appearance. A few hours later severe pain occurred in the region of the tumor, swelling increased, and on the second day vomiting began and persistently continued, and from the history was stercoraceous the last two days previous to admission to hospital. Bowels had moved only after large rectal injections, and then but slightly, most likely simply emptying of the lower bowel. No flatus passed after the first symptoms of strangulation. This patient was sent to me by Dr. George B. Reynolds. She had been repeatedly urged, but declined all operative interference until the day of her admission. On admission she had stercoraceous vomiting and was in a very feeble condition, hiccoughing, tongue dry and coated, pulse 120, small and wiry. Temperature rather below normal; in fact she was in a state of collapse. In the left groin, and in the position of inguinal hernia, was an inflammatory swelling; tense fluctuating tumor, resonant on percussion. The skin looked as if it would shortly give way from the suppuration beneath.

Operation :—The patient was at once placed under the influence of chloroform, and an incision made. A large amount of stinking pus and gas escaped, and a loop of the small intestine was found protruding at the external ring of the inguinal canal. The most of this loop was gangrenous and the rest covered with lymph. The length of gangrenous gut was three inches. The incision was carried through the abdominal walls for some four inches, but previous to this a gangrenous tissue around the ring was as thoroughly as possible dissected away, and the wound made as clean as could be under the circumstances. The gut was then drawn down, and after clamping above and below, the damaged part, which was five inches long, was excised close to the mesenteric attachment, and the mesenteric edge folded by a few silk stitches, which readily controlled the hemorrhage. The gut was then reunited by means of the Murphy button.

The abdominal wound was then closed by silk sutures, after packing the lower end of the wound or abscess cavity, which it really amounted to, with iodoform gauze. During the operation, which lasted thirty-five minutes, the patient became so depressed that injections of strychnia, nitroglycerine and whiskey were necessary. When she left the operating room her pulse was very rapid and scarcely perceptible at the wrist; was hiccoughing, which soon ceased after being placed in bed. Hot bottles applied, milk and whiskey freely given, an hour after operation. There was no vomiting at any time after the operation, and the temperature remained normal during her entire illness except the first evening, when the highest point reached was 100½° F. Milk diet exclusively for the first six days; seventh day allowed soft boiled egg with softened toast. Tenth day bread and meat in small quantities. The button passed without discomfort on the eleventh day. March 19, twenty-six days after the operation, patient sitting up; bowels moving regularly, without pain or discomfort; taking the regular house diet and rapidly gaining strength and flesh.

CASE 2.—Mrs. H., married, aged 68; had had hernia for some years, but had never worn a truss. She had always been able to return it herself when it came down. On the evening of March 19, three days before I saw her in consultation with Dr. W. S. Green, while doing some work in her garden, she was taken with severe pain in the region of her hernia. The pain continued and she persistently vomited during that night. Dr. Green was called the next morning and found her suffering from all the symptoms of strangulated hernia. He immediately tried to reduce the hernia, under the influence of chloroform, but failed. The pain and vomiting and all of the symptoms continued during that day. Morphia was administered during the night, and the patient slept some. At an early visit of the doctor next morning, pain still severe, vomiting stercoraceous matter. I saw the patient on the evening of the third day; a femoral hernia, which was small but hard and tense. There was no evidence externally of inflammation. Her temperature was normal, pulse 110, and she was very feeble, and much collapsed, and very apathetic, which was, I think, more apparent than real, likely due to the fact that she was under the influence of opium. The operation was at once commenced; Dr. Green and I having for our assistants a gentleman who, under his instruction, after he first put her under chloroform, administered the anæsthetic, and a youth of 18 years held a large kerosene lamp which furnished our all though imperfect light. The incision exposed a small knuckle of intestine, which was dark, but in appearance had a good polished surface. In the effort to incise the narrow neck of the hernia, the gut gave way, and a rush of fecal fluid was seen escaping from the opening. After enlarging the ring the gut was gently pulled down, when it was made out that about three inches of the intestine was damaged. We then disinfected the loop as thoroughly as possible with hot bichloride water; the gangrenous portion was cut out after the clamps had been placed. The mesentery was folded over itself and stitched with silk, and the divided gut was brought together end-to-end, by means of the Murphy button. After uniting with the button, there was considerable difficulty in returning the bowel into the abdomen, and it became necessary to divide Poupart's ligament before this could be satisfactorily done, and there must of necessity have been considerable strain put upon the united point, though every care was taken to protect against such a strain. The sac was then dissected out, and the ligament stitched with two deep silk sutures. The outer wound was brought together with a continuous suture, and the wound dressed with sterilized gauze. Time of operation twenty-five minutes. The patient had some pain for the first four days after operation, which made it necessary to give one-quarter of a grain of morphia every four or six hours. Considerable tympanites with slight delirium, which was probably due to the morphia. Had two small liquid stools on the fifth day;

passed much flatus. The button was passed on the ninth day. Much pain and continuous desire to stool the eighth day or the day previous to passage of the button. She had two constipated stools the ninth day after the button had passed. Gave half an ounce of castor oil on the thirteenth day, which moved bowels freely, and they have been regular since. During her illness the pulse rate was from 85 to 90, only once reaching 108. Temperature ranging from 99° to 99½°, and once during her illness did it reach 100½°. Diet: Milk and beef tea. The dressing and stitches were removed on the eleventh day. The wound was found entirely healed. April 19, one month after the operation, patient was able to sit up and is considered by her doctor to have recovered.

The question as to what is the best method of dealing with a gangrenous hernia is far from being definitely settled. Granted that the patient's general condition is such that they will not offer the most favorable chances for recovery from any severe operative procedure, is it better to leave the gut alone, and subsequently perform an operation for the closure of the artificial anus which will of necessity follow if the patient survive —or is it better to perform a primary section of the gut, and add thereby some additional risk to the patient? The secondary resections are not free from dangers or difficulty. The marked adhesion, the dilated approximal end and the contracted distal end, occasion much delay in the end-to-end anastomoses, as well as the risk of the patient being starved when the gangrenous point is high up in the small intestine. The strongest arguments that have been offered against the primary resection have been that the time necessary to carry out the essential manipulation was more than the patient's general condition warranted, with any degree of safety. Fortunately for either operation as far as the technique is concerned, it is no longer felt absolutely essential to resort to the more or less complicated time-killing form of suture. The average amount of manipulative skill will enable the operator to bring the peritoneal surfaces of the divided intestine into adequate contact with each other by the use of the Murphy button, in from five to eight minutes. The procedure is simple, and has the inestimable advantage of being quickly done. The depressing nature of the original cause that requires a resection, and the operation for resection of the bowel, by any method of stitching so far devised, consumes time which under these circumstances means but little less than a measure of shock and danger. Therefore, any method that shortens time and lessens the necessary manipulation will most likely add much to the favorable results obtainable by primary resection. The experience gained by the two cases above reported make it seem likely that the use of the Murphy button is worth a more extended trial in this class of lesion.

Puerperal Convulsions and True Epilepsy.—Paquy (*British Medical Journal*) recently read notes at a meeting of a society on a patient who was frequently attacked with epileptic fits. She became pregnant, and at delivery had 119 fits. The temperature rose to over 102°. The diagnosis between puerperal eclampsia and epilepsy depends on the history and on the absence of albuminuria in simple epilepsy. Charpentier observed a similar case. An epileptic patient had convulsions during her first labor, became pregnant again, and died after a succession of fits during the fourth month. He agrees with Paquy as to albuminuria as a diagnostic factor.

Ocular Headaches.—Dr. F. D. Green (*The Refractionist*) concludes an article on headache as follows:—

1. Many cases of headache are due to ametropia.

2. Many cases are due to heterophoria.

3. Never pronounce a case as due to ocular strain until the nose is examined.

4. Inquire into the condition of the stomach.

5. In females inquire concerning the condition of the genitals and whether there is constipation.

6. Migraine may be due to ametropia or heterophoria, but frequently is not.

CHRONIC INFLAMMATION OF THE MIDDLE EAR; CEREBRAL ABSCESS; DEATH.

Read at the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 24-27, 1894.

By W. M. Nihiser, M. D.,
Keedysville, Md.

W. C. W., at about the age of four, had an attack of measles which left him with a purulent discharge from the left ear. This discharge was more or less offensive, and continued for twenty-four years; there being intervals in the meantime of a few days or perhaps a week or two that no pus would flow from the ear.

During the twenty-four years of this trouble he consulted Dr. Chisolm, of Baltimore, and was treated by him in 1885 and 1886.

He was also treated by Dr. Humrichouse, of Hagerstown, in 1888-89. Dr. Humrichouse tells me he was able to detect quite a small opening at the upper part of the drum, in Shrapnell's membrane.

During all these years he was able to perform his daily avocations. From ten years prior, and up to the termination of this trouble, he was agent and operator of the B. & O. Railroad at Germantown, Md. It did not prevent him from acting in the capacity of telegraph operator, yet he was fearful that he would completely lose the use of that ear at some time.

His hearing at times was affected very much on that side. He was compelled to keep a piece of absorbent cotton in the ear all the time. The discharge was nearly always very offensive. His general health you would consider good. He was never confined to the bed over forty-eight hours at any one time since the attack of measles.

There is some history of tubercular trouble on his mother's side. His voice was rather effeminate; his eyes were inclined to be weak. He was a man of good habits.

Three weeks prior to death he was taken with what was supposed to be grippe—he complained of pain in the head, chilly, loss of appetite, bowels costive. He was treated by a physician in Germantown. A week prior to death he seemed somewhat brighter and more free from pain in the head. The pain in the head was relieved considerably after a more free discharge from the ear. He was brought home to Keedysville on the train at that time and I saw him for the first time about 8.30 P. M. He was sitting up on a sofa and spoke to me quite cheerfully. At no time had he kept his bed during this attack, but was up and down and would sometimes walk the floor, especially when the pain in the head was very severe.

I questioned him pretty closely as to his condition; he answered me only fairly well; at times he would go off onto some other subject. He seemed to be in a somewhat dazed condition, at times bright, at other times dull, and not able to answer questions. His tongue was heavily coated; bowels costive; temperature 101⅘°; pulse normal; pupils normal; some headache; not much discharge from the ear. I gave him acetanilid for pain in the head, and a brisk cathartic —containing calomel, ipecac and soda— which acted well.

I saw him the next morning. His head was somewhat better; temperature 100°. His condition did not change during the two days following. On Thursday his temperature had gone down to nearly normal, at which time he seemed a little more dull and stupid; he would have paroxysms of pain in the head, which would cause him to be very restless, for which I gave him bromide and morphia for relief. On Saturday I asked to operate by trephining but was refused by wife and all. It was imperative that something be done, yet my hands were tied by the refusal to allow an operation.

I detected on Saturday morning a slight boggy feel immediately back of

the ear that was affected, and at the same time I thought I could detect pus there. I concluded to cut down and see. I knew if the pus could not be found, the fact of letting out some blood would tend to relieve some of the symptoms.

The family agreed that I could operate. I did so by cutting down to the bone, and about a teaspoonful of pus was obtained. It had burrowed its way from the auditory canal back and next to the bone, forming a small pocket or sack there.

This did not relieve any of the untoward symptoms. On Thursday previous to this I had applied a blister back of the ear, yet no good came from it.

Saturday night his condition remained unchanged; was still restless, and threw his legs about from side to side, his right arm was noticeably quiet, breathing regular, pupils normal, pulse somewhat quickened, some difficulty in swallowing, sometimes he would moan.

On Sunday I consulted with Dr. Davis, of Boonsboro, and he agreed with me as to the diagnosis, and also urged trephining, but to no avail.

Sunday night was a bad night for him, only sleeping for a short period at a time. Legs and left arm almost in constant motion. I was with him until 1 A. M. Monday morning. Saw him again at 8 A. M. Found him in a comatose condition and unable to swallow. At 10 A. M. he had a slight convulsion, followed by two more at intervals of about fifteen minutes; at 10.45 death ensued.

A post-mortem was immediately held, at which I was assisted by Drs. Davis and Henry B. Wilson, of Boonsboro. The top of the skull was removed. The external surface of the brain presented a marked venous stasis, every vein being thoroughly distended with blood. On raising the brain from the affected side, the abscess ruptured and at least four ounces of the most foul-smelling, green-colored pus ran out into the vessel beneath. Further examination showed that a small opening, about an eighth of an inch in diameter, occurred in the dura mater, forming a direct connection between the auditory canal and the abscess, which was shown by passing a probe from without inward. The abscess was located in the inferior portion of the tempero-sphenoidal lobe of the brain, resting on the petrous portion of the temporal lobe and including the whole lobe. There was some caries of the bone beneath the aperture in the dura.

I am unable to give the anatomical relations, only in a general way, as the post-mortem was made hurriedly under a promise to the family. Our resources for anatomical knowledge in the country, as you well know, are meagre, and as to post-mortems, they are rarely allowed.

The gravity of this case was realized from the first time I saw him, and I so communicated the fact to the wife and parents of the man, and urged an operation as the only chance for his life; this being refused there was nothing else to be done but await results.

It was a question whether an operation five or six days prior to death would have given him permanent relief or not.

Another question which seems difficult for me to answer is, when did this perforation in the dura-mater occur, and how long was the abscess forming?

Did the perforation take place and the abscess begin to form at the time when it was supposed the grippe commenced, which was three weeks prior to death?

Another question of great importance is: When shall we operate or urge an operation?

The symptons of this case hardly warranted an operation until within a week of the fatal termination.

Spitzka, in Pepper's System of Medicine, says in relation to abscess of the brain, "that the most frequent cause of cerebral abscess in civil practice is suppurative inflammation of the middle ear."

He also says it may be safely asserted that the person suffering from this affection is at no time free from the danger of cerebral abscess, a purulent meningitis or a phlebitic thrombosis of the sinuses.

Of the six cases of this character which he reports, in four of them the abscess was in the temporal lobe.

As regards treatment, the majority of cerebral abscesses are not influenced by medicinal measures and very often not by surgical treatment.

Gussenbauer was able in one instance, from the fluctuation of some symptoms and the predominance of others, to surmise that his patient had an abscess in the frontal lobe; the suspicion was verified, an abscess the size of an apple was found, opened, and emptied of its contents. The patient recovered without any immediate untoward symptoms; yet epileptic and focal spasms subsequently developed.

The uncertainty of localization in some districts of the brain are so great that a number of attempts to repeat the explorations and aspirations of Wernicke and Gussenbauer have failed.

In one case operated on in New York City, the aspirating needle was run into the brain substance in several different directions without striking the pus.

The medicinal treatment of abscess of the brain is limited chiefly to derivative methods, which are very uncertain and of doubtful action. Benefits have been claimed from the free use of mercury in the form of calomel. Yet in conclusion it seems that no specified line of treatment can be followed in these cases and each case calls for its own kind of treatment and management.

SOCIETY REPORTS.

ASSOCIATION OF AMERICAN PHYSICIANS.

NINTH ANNUAL MEETING IN CONNECTION WITH THE THIRD CONGRESS OF PHYSICIANS AND SURGEONS AT WASHINGTON, D. C., MAY 29, 30, 31, AND JUNE 1, 1894.

Stenographically reported for the MARYLAND MEDICAL JOURNAL by a member of the staff.

Dr. Reginald H. Fitz, of Boston, delivered the President's address, which was on the subject of medical legislation in Boston and of local interest.

Dr. Beverley Robinson, of New York, read a paper on THE TREATMENT OF CERTAIN SYMPTOMS OF CROUPOUS PNEUMONIA, PARTICULARLY IN ADULTS. Two important symptoms of pneumonia are pyrexia and pulmonary congestion, and for them the modern antipyretic drugs are not useful except in large doses. Of these, phenacetine is the best; antipyrin is not as good and is depressing in large doses. It should be given only when the temperature is over 105°. Such simple drugs as spirit of mindererus and citrate of potash are better with quinine in doses from three to five grains. Cold baths are not of especial efficacy and are not frequently used in this country outside of hospitals. When the temperature is 104° and over, the tub bath of 80° to 90° may be used, and while it may not lower the temperature, when combined with friction it quiets delirium and stimulates the circulation. The bad results are occasioned when the body is immersed. Cool bed baths are very satisfactory and have the advantage of avoidance of moving and shock thus entailed. Such a bath should last for 15 to 30 minutes. It gives relief, the temperature falls, there are no complications from it, and it can be given more conveniently than the immersion bath. Aconite is not advised, even with digitaline; it poisons the heart, for it is weak and may stop in the diastole. Aconitine also is a virulent poison and not adapted to general use, but when employed it is better combined with digitaline. However, the advantages are not sufficient to justify its use. Other drugs are more useful and less dangerous in these two conditions; antimony, for instance, in small and repeated doses. The oxysulphuret of antimony, or Kermes mineral, 1-32 of a grain every two or three hours, makes the sputa more fluid and the expectoration more easy and free from irritation. It does not produce that collapsed condition in old people and children. Alcohol also, both externally and internally, is good, except when there is much diaphoresis. Trousseau advised antimony, but the wrong salt was given and in too large doses. Kermes mineral is not depressing and is of value as an expectorant and in other ways; it loosens the expectoration and makes it fluid. When the heart is unduly taxed and there is congestion of the lungs, the action of nitroglycerine is both rapid and

favorable, not in 1-100 of a grain, but 1-50 and even 1-20. The pulse is no guide to its use. The labored and panting breathing will be modified. The inhalation of oxygen affords relief with some exceptions; in some it does harm. It is not easy to account for the different results. Let the patient drink plenty of water; not enough is given at the present day. Water produces diuresis and lowers the temperature. Alcohol is undoubtedly beneficial; it is an acceptable food; it prevents tissue waste; relaxes the blood vessels and helps the engorgement and gives nerve force. It is generally judicious practice to use it for any of the conditions named. It is contra-indicated when the patient is plethoric and when there is hepatic congestion and gastric catarrh; then give calomel; it helps the circulation and respiration. The two dangers in pneumonia are heart failure and pulmonary œdema; they may come on suddenly or gradually; there is danger of vascular paralysis. He was formerly opposed to the use of digitaline and has come to his present good opinion of it slowly. It increases the power of the heart but it closes up the small vessels, which we wish to avoid. Hypodermics of strychnia 1-60 to 1-30 of a grain are beneficial, but they occasionally cause nervous irritability. Hypodermics of coca, made antiseptically, have also been used with advantage, but nitroglycerine and strychnia are the best drugs. Bleeding is an excellent remedy and is not to be ignored when there is much congestion and drugs have no power. When the patient is an alcoholic nothing will help and we are handicapped, but bleeding is our last chance, and after bleeding strychnia and digitaline may be used. After venesection use hypodermic injections of sterilized salt solution to supply the lacking chlorides. They prevent ante-mortem heart clots. Frequent doses of black coffee should be given; caffeine is not as desirable; it is only an alkaloid and has no nutritive power. The trinity pill of arsenic, strychnia and digitaline is not as good as his treatment.

Dr. George L. Peabody, New York, thought at the present time the symptom treatment was the best and one which he has used. Two important symptoms which Dr. Robinson had not mentioned are pain, together with insomnia from the pain, or from an irritating cough, which is out of all proportion to the good it does in promoting the expectoration. The cough is generally of little relative importance in promoting expectoration. He finds the best thing to use is morphia in the smallest doses; it is not right not to give morphia; the respiration is helped by it and the heart stimulated and there is nothing better. He believes in cold water, but not unless the temperature is 103° and over. As to the experience in heart clots in pneumonia, he has made a large number of post-mortems after pneumonia and has rarely found heart clot as a cause and he thinks one is apt to mistake post-mortem heart clot for ante-mortem clot.

Dr. James C. Wilson, Philadelphia, thought that there were extreme variations of the disease, both clinically and pathologically; as it occurs in youth, in middle age, old age, in alcoholics, tuberculous pneumonia, single, double, apical; all these give us a series of clinical pictures and each must have its own treatment. It must be a treatment of expectancy and more than this the general symptomatic factor must enter largely. Take the sthenic variety or any other kind and the expectant treatment seems to give the best results. He has not been satisfied with the cold bath in his experience. Local application of cold is at times beneficial. Statistics on pneumonia are very unreliable unless a large number of cases of the same kind be brought together. He has had great benefit from cold effusions; water poured over the head and shoulders. In venesection too much attention is paid to the mechanical indications of blood-letting. Blood-letting draws from the body elements of toxicity. This is of benefit when the mechanical indications are not well marked. It is not only safe, but advantageous to give opium unless there are distinct contra-indications. Two to three grains of Dover's powder every two, three or four hours will relieve the pain and restlessness of

the patient and soothe the agitation. The injections of sterilized salt solutions had been used very greatly by Dr. Henry, of Philadelphia, with benefit.

Dr. Victor C. Vaughan, Ann Arbor, Michigan, said it was very evident that Dr. Robinson had not used true digitaline, but digitoxine. This is a strong poison.

Dr. Robinson said, in conclusion, he wished to point out the futility of the treatment of pneumonia by the trinity pill and to direct attention to the fact that we are using drugs in a way to show that we do not understand.

Dr. Samuel A. Fisk, Denver, Colorado, exhibited a composite chart showing the temperature of THIRTY CASES OF TYPHOID FEVER, running through three years. The mean temperature of the morning and evening temperatures is taken and this shows a steady decline in both temperature and pulse rate and he thinks it goes to show that typhoid fever runs a milder course in Denver than in the east and the chart is very unlike the one which he showed from Pepper's System. His treatment is five grains of calomel followed by a saline, peptonized milk every three hours, followed by a prescription containing turpentine, castor oil, subnitrate of bismuth and mucilage of acacia. Plenty of water is given ; Dover's powder for the delirium, sponging for the high temperature, whiskey with digitalis or strophanthus if necessary. Milk in abundance.

Dr. I. E. Atkinson, Baltimore, referred to two points, one, as to milk; he agreed with him as to milk being a proper diet, but with some qualifications, towards the end of the disease when the diarrhea is under control. There is much difficulty in giving milk in this disease. The undigested casein accumulates in the rectum and more than once he has seen the fatal end brought on by the labor-like efforts to expel the mass. Insomnia as a symptom is of extreme importance, especially the coma vigil. He had abandoned the ordinary hypnotics and sometimes gave slight inhalations of chloroform. Amelioration of the general symptoms followed this and coma was prevented by the cold bath. All the symptoms were modified favorably by this treatment. One or two cases widely differing would greatly vitiate the value of such a chart.

Dr. Charles F. Folsom, Boston, thought that Dr. Fisk might have had many cases with no deaths at first and many with deaths at the end and the average would be the same. He must have had very mild cases. He himself had been rash enough to generalize once after 150 cases, and he often wished he could recall that paper. The number of cases is too small. He used all kinds of medicine and found them of little effect.

Dr. J. F. A. Adams, Pittsfield, Massachusetts, thought the charts looked as if the typhoid fever had been influenced by intermittent fever and referred to the change in the course of typhoid fever as intermittent would make.

Dr. Wm. Osler, Baltimore, thought this paper was interesting as illustrating the common therapeutical fallacy. Dr. Fisk was not treating typhoid fever, but was giving medicine to his patients and friends. The cases did not require treatment and he evidently had very mild cases. The mortality with the Brand method at the Johns Hopkins Hospital in 80 cases was 6 per cent. in unselected cases in a general hospital. Malaria and typho-malaria were excluded.

Dr. Victor C. Vaughan, Ann Arbor, Michigan, said that Dr. Osler was a nihilist, as he had written a book on medicine, and therefore did not believe in it. The castor oil and turpentine did the work. The medicines were not thrown away.

Dr. Charles F. Folsom, Boston, reported SIX CASES OF TRAUMATIC HEADACHE, in all of which an accident of some sort, as a fall or a blow, had caused a headache and an operation had effected a cure. In most of the cases an examination of the nerves in the scar showed marked interstitial neuritis.

Dr. M. Allen Starr, New York, thought that headache was such a common symptom that it was a very serious matter to recommend such a severe operation as trephining and yet there

are cases in which we come to this as the last resort. He referred to a case of head injury in his practice in which the boy's entire disposition was changed and his family could not get along with him; he had attacks of rage with mania. The principal symptom was pain. There was no fracture found in the internal table and no pathological adhesions. Pain is the exception in his opinion in these cases. The dura was congested and there was a marked lesion in the cortex much like an angeioma; this was removed and the brain was punctured with a hypodermic in several directions to look for a possible cyst; none was found, the boy recovered and his disposition was changed for the better. Trephining was done over the posterior portion of the brain away from the motor centers and after the operation there was loss of muscular sense in the arm and also loss of sense of the position of that member. There was no loss of motor power. It is the only case on record of loss of muscular sense and as the injury was cortical it looks as if the muscular sense had a center apart from motion and sensation.

Dr. Frederick P. Henry, Philadelphia, made a clinical report of TWO CASES OF RAYNAUD'S DISEASE. One was in a man who noticed first a cyanotic condition of the halices of both ears, then of the face and nose and then he passed a large quantity of dark cherry-colored urine, which contained blood pigment, but no bile. For the detection of this he had found the guaiacum test the best, but it does not act in the presence of albumen. The other case was in a woman, who gave no history of syphilis and had no metrorrhagia. She had great disturbances of the circulation with blackness of the end of the nose and the tips of the ears were dark and painful. The urine did not show the presence of hemoglobin like the last case, but there was marked scleroderma. There was nothing abnormal in the internal organs. In Raynaud's twenty-five cases, twenty were in children and it is sometimes called juvenile gangrene. The theories are: 1. That it is due to an endarteritis obliterans. 2. To a peripheral neuritis, and 3. To vascular spasm. The last is probably the most tenable theory, the hemoglobinuria is caused by the hemoglobin from the asphyxiated parts. There may also be hemoglobinemia. Nitroglycerine in one case seemed to be of benefit. As the warm weather approaches cases appear to do better. Some have recommended electricity.

Dr. Henry M. Lyman, Chicago, thought that some of these cases had chronic arthritis and the relation of arthritis to this disease should be borne in mind.

Dr. William Osler, Baltimore, referred to two cases reported by Dr. H. M. Thomas, of Baltimore, which only occurred in winter and never in summer. There was active hemoglobinuria with cerebral symptoms. Aphasia may come with this disease with or without hemiplegia.

Dr. M. Allen Starr, New York, believed that the disease could be undoubtedly outgrown. He saw a case in a child in 1884 and in 1887 the disease had stopped.

Dr. William H. Welch, Baltimore, said the cause of the hemoglobinuria was not clear; some thought it was referable to the vascular spasm, but the connection between the two is not easy to see. We do not clearly understand it, but we do know that under the influence of cold hemoglobin becomes separated from the blood and we have a condition of hemoglobinuria.

Dr. Henry said, in conclusion, that the arterial spasm caused a rapid venous congestion and thereby produced a local asphyxia with hemoglobinuria and hemoglobinemia.

Dr. Harold C. Ernst, Boston, then reported on the late Dr. S. C. Martin's RESEARCHES ON THE BACTERIA OF VACCINIA showing the result of Dr. Martin's work on the bacteriology of cow-pox. From his pure cultures he had inoculated arms which showed the typical pustule of vaccination. As the results of his investigation he concluded that: 1. The germ of cow-pox is a bacterium. 2. In different stages of its development it is a coccus or bacillus. 3. It can be iso-

lated and grown in a pure culture on blood serum at the temperature of the blood; and 4. Inoculations on the calf from such cultures readily produced the typical cow-pox, while inoculation in man produced typical cow-pox but once in eleven times.

Dr. William H. Welch, Baltimore, thought this was a very important work. The methods are simple and it is done in other countries. This work needs going over and the results need confirmation; they are in opposition to results obtained by others. There is nothing difficult in the procedures recommended.

Dr. A. C. Abbott, Philadelphia, had had no personal experience with this work, but he agreed in the main with Dr. Welch that the work needed confirmation.

Dr. George M. Sternberg was also of the same opinion.

Dr. Ernst thought that the work of Dr. Martin was reliable and felt that it would stand.

SECOND DAY, WEDNESDAY, MAY 30.

Dr. Theobald Smith, Washington, read a paper entitled MODIFICATIONS, TEMPORARY AND PERMANENT, OF THE PHYSIOLOGICAL CHARACTERS OF BACTERIA IN MIXED CULTURES. This was the result of experiments in growing the proteus vulgaris with a pathogenic organism which showed that the latter lost its virulence when the proteus flourished and when removed from the proteus and grown by itself it regained its strength. He dwelt on the antagonism between bacteria and ptomaines and showed the effects of the inoculation of two kinds of bacteria in the body at the same time. This shows the possibility of modifying the growth and virulence of pathogenic bacteria.

Dr. George M. Sternberg said this was a very instructive paper. A few years ago bacteriologists thought that different appearances of cultures showed different species and Koch taught this. Our bacteriologists followed this and when they found that one bacillus looked like another, but was different in cultures, they thought they had differentiated it. Booker was of this opinion and got out a great number of bacteria that resembled each other and yet which grew differently and he was greatly confused as to whether they were different bacteria or different varieties of the same species. The same organism may undergo different changes. Phosphorescent bacteria may fail to produce phosphorescence, and pigment bacteria fail to produce pigment and yet they are of the same sort. He had gone through the same thing in his investigations in Cuba. The colon bacillus had a different appearance in culture tubes and roll tubes.

Dr. William H. Welch, Baltimore, said there were changes in function without morphological changes and he referred to the work in hog cholera and thought that Metschnikoff, Seelander and others in Germany were working with a different organism from what we are working with in this country and yet we both call it the hog cholera bacillus. The lesions caused by this organism in the intestines of the rabbit he attributed to an attenuated bacillus. The organism seems to be affected by other organisms and the proteus certainly modifies the growth and appearance of other organisms.

Dr. Smith, in conclusion, said with reference to the typhoid-like lesions in hog cholera, produced by the attenuation of the germ, and as to the work of Seelander, the Bureau of Agriculture would soon publish his investigations on this subject.

Dr. Meade Bolton, Baltimore, then read a paper on THE EFFECT OF VARIOUS METALS ON THE GROWTH OF PATHOGENIC BACTERIA. Some metals have no effect on the growth of bacteria, while some have a marked inhibitory action and this was shown in the different zones around the pieces of metal in the cultures.

Dr. William H. Welch, Baltimore, was very familiar with this work. The intensified zone around the clear zone contains the least amount of metal, but the clear zone outside is not easy to understand. The first zone is easy to explain. The small amount of the metal is favorable to the growth of the organism, while the large amount of metal is inhibitory. This has many parallels.

Dr. Theobald Smith, Washington, then asked if attention were paid to the culture media used and the reason he asked this was because he had found that beef bought in the markets varied at different times and sometimes contained more sugar than at others.

Dr. Bolton said he used an extract always from the same bottle.

Dr. W. Gilman Thompson then read a NOTE ON THE OBSERVATION OF MALARIAL ORGANISMS IN CONNECTION WITH TYPHOID FEVER. It has always been a question whether the two diseases can occur concurrently or whether the presence of one can affect the course of the other. Do we recognize a combined disease? The disease typho-malaria is more spoken of in the south than in the north. All the forms of fever in the south seem to be influenced by malaria and quinine is generally used with good effect, while it has no effect on typhoid fever. He related a case of typhoid fever in which there was a chill on the thirteenth day; he gave quinine and the temperature was reduced and no more chills occurred. This was undoubtedly typhoid complicated with malaria. The other two cases were of the same kind. He concludes that while it is unwise to use the term "typho-malarial fever," still there are cases where the two diseases co-exist even where it is not to be looked for.

Dr. William Osler, Baltimore: The first case mentioned was unusually interesting and he knows of another case in hospital where the two diseases ran concurrently. It is a great mistake to suppose that all cases of typhoid fever with chills are malarial. It is notorious that chills in typhoid fever are by no means uncommon and he had had cases with chills where there was no malarial organism. He showed a chart of a case with a double infection. He had malaria when he came into the hospital and later typhoid fever came on. He had recently seen a case where pneumonia and malaria where concurrent.

Dr. F. P. Kinnicutt, New York, thought we should be guarded as to the frequency of such occurrences without further observations. He showed a chart of a case who had lived a long time in Central America and had had malaria and it had influenced the course of his typhoid fever. In all his cases he always examined the blood.

Dr. George L. Peabody, New York, said there were chills other than malarial chills and they were more important, and by the examination of the blood it was possible to differentiate between the chills of malaria and pyemia. He had seen two cases in which chills occurred late in the course of the typhoid and at the autopsy he found pyemic abscesses in the kidney. The chills may mean nothing and we should not put our seal of approbation on such a disease as typho-malaria.

Dr. E. G. Janeway, New York, said the chill might be due to the treatment. The antipyretics in large doses depress the temperature and as it rises the chill will come on. Drop your antipyretics and the chill will not occur. This was particularly true of the coal-tar derivatives. These are called medicinal chills. The combination is a phenomenon found at autopsies and he had seen the pigmentation and the typhoid lesions. In one case the history did not show malarial symptoms. It was typhoid fever. This woman was being delivered by forceps of a child in the amphitheatre by a man, when she developed chills within thirty-six hours. The man who delivered her was the assistant demonstrator of anatomy, and it was of course thought that the chills were puerperal fever, but the discharges from the uterus were normal and nothing pointed to it. She died in the third week and at the autopsy were found a pigmented spleen, a pigmented liver, and it was clear that there was a co-existence of the two diseases. He did not like the name typho-malaria and would prefer to call it typhoid fever with malarial co-existence. Physicians called the disease typho-malaria to conceal the true state of things from the family and by so doing they do harm, for they take away the means of prevention which would be taken if it were known to be typhoid and thus do a great deal of harm. To this is due in part the spread of typhoid fever.

Dr. George M. Sternberg, Washington: The first case showed clearly a mixed infection which is rare; the other cases are simply the development of malaria in the course of typhoid which is not rare. It is not cases of this kind that are called typho-malaria, but the typho-malarial cases are in reality mild cases of typhoid without the distinct malarial paroxysms and the high evening temperature which lead the physician to say it is malaria, and he gives quinine. The temperature is as in typhoid fever, but the rose spots are absent or delayed and there is constipation. He had studied the statistics during the late war and found that malarial and typhoid fevers were more common than typho-malaria.

Dr. James C. Wilson, Philadelphia, thought the name typho-malaria had done incalculable harm, for this confusing name has delayed the knowledge of the disease for more than a generation, at least in the south. He also referred to cases with typhoid symptoms or cases in which malarial fever is already there or comes after typhoid. He thought typho-malaria was a very unfortunate term and should not be continued.

Dr. J. H. Musser, Philadelphia, reported a case of mixed or repeated infection.

Dr. Henry M. Lyman, Chicago, recalled similar cases of mixed infection.

Dr. William T. Councilman, Boston, referred to a case of typhoid fever with the autopsy.

Dr. Frederick C. Shattuck, Boston, said that thrombosis or phlebitis might cause chills; he always examined the blood.

Dr. J. C. Reeves, Chattanooga, Tennessee, said that this term was a constant source of confusion in the south. The disease in his State was a gastro-hepatic involvement and was a disease *per se*. It occurs most commonly in children and he believes it is an intermediate specific form of fever between malaria and typhoid.

Dr. George Dock, Ann Arbor, Michigan, said he hoped that Dr. Thompson's observations would be followed by others, as that is the only way to make it clear and the mere relating of these cases goes a very short way to prove anything. Dr. Osler's first case of malaria had no effect on the course of the typhoid. He does not believe in the mildness of this form of fever. He had seen no cases while practicing in Texas and had seen cases in Michigan and New York.

Dr. Thompson, in conclusion, said that these cases of his and Dr. Osler's show that the malarial organism may be present all through and may not show itself until the typhoid fever is all through. Just how it may influence the disease is not easy to say. We should always make it a rule to examine the blood and give quinine.

Dr. George Dock, Ann Arbor, Michigan, then read a paper on EXPERIMENTS IN ARTIFICIAL MELANOSIS. He was led to make these investigations by studying malaria and noting the connection between it and phagocytosis. In his experiments he used dogs and rabbits and injected lamp black instead of cinnabar. The pigment was only in the polynuclear cells. He has been led to change his opinion of phagocytosis. He believed that in melanosis and other diseases the large macrophages of Metschnikoff play an important part.

Dr. Thomas M. Rotch, Boston, then read a paper on SOME OF THE CHEMICAL AND BACTERIOLOGICAL CHARACTERISTICS OF MILK. He made some studies on the reaction of milk and studied the effects of beets, given to the cows, on the milk. He found that he could govern the reaction of milk and that when a little of it was alkaline, when mixed the whole would be alkaline. The first part of the milk may contain bacteria but the last part is free from them. These bacteria may come from some part of the milk tract. Milk for children should be sterilized. He examined the ash of milk and found silicon in it.

Dr. F. Forchheimer, Cincinnati, said that milk to be perfectly good should be alkaline and most of the milk used was acid. The normal reaction of milk is undoubtedly alkaline and the efforts of Dr. Rotch were laudable. The mere adding an alkali to milk is simply adding another element to bad milk. The great number of deaths from infant di-

arrhea is due to impure milk. Infants should be protected against milk sepsis. There is great room for reform in this direction.

Dr. Theobald Smith, Washington, said that in connection with bacteria in milk, he can give one illustration. Some milk was brought to him for examination and he found in it the pyogenes staphylococcus and pyogenes aureus; a rabbit inoculated with it died and a guinea pig inoculated with it died. There were polynuclear cells in the milk.

Dr. Rotch said that the last half of the milk was much purer than the first half and when milk was suspected the last half alone should be used.

THIRD DAY, THURSDAY, MAY 31.

Dr. J. P. Crozer Griffith, Philadelphia, read a paper on TETANY IN AMERICA, in which he reported five cases. The spasms are sometimes intermittent and sometimes continuous. The treatment was sedative to the nervous system. Three cases were fatal and only as a result of complications. He had examined records of all cases occurring in this country; they occur in adults and children.

Dr. W. Gilman Thompson, New York, was greatly interested in these cases; he reported a case in a male, 35 years old. The disease lasted six weeks and no cause could be found. The spasms were in the face and to a marked degree and were practically continuous for several hours and then moving the patient would bring them on again. They gradually subsided.

Dr. E. G. Janeway, New York, had seen two cases in connection with typhoid fever; one in a man of 30 to 40 who had a very severe attack of typhoid, temperature 106°, pulse beyond 150. In the mid-period of the disease there came on tetany of the face, jaws, back and there was difficulty in giving food and medicine. The gastro-intestinal tract showed the disease by passing a membranous cast of the intestines and this confused the diagnosis. There was Cheyne-Stoke respiration. This lasted about two weeks. It looked like meningitis. There is sometimes sinus thrombosis. The other case was also interesting.

Dr. Charles G. Stockton, Buffalo, reported a case of a child four years old with carpo-pedal spasms for two months; it had dilatation of the stomach and at times there would be complete suppression of the urine, not more than two to three ounces in the 24 hours. The child had œdema and also probably a cystic kidney. Under baths it improved and now for two years it is practically well.

Dr. Abraham Jacobi, New York, said that in regard to the rarity of laryngismus stridulus, in his experience it was quite frequent and when Dr. Griffith said it was rare it quite struck him that the reverse was true. It is so common that few cases are reported. He sees a dozen cases every season. In quite a number of children it occurs with rachitis which is becoming more frequent. It is very seldom fatal.

Dr. James J. Putnam, Boston, thought that tetany must be a very rare disease; he had seen many hundred cases of nervous disease and only two typical cases of tetany with carpo-pedal contraction. In one it was continuous, for which no cause could be assigned. It came and went without being possible to assign a reason. As regards its connection with rickets, the negroes in Boston are very subject to it. He had seen a case of spasms so severe that the child had spinal meningitis.

Dr. William Osler, Baltimore, reported a case that came on in the sixth month of pregnancy for six pregnancies.

Dr. James Stewart, Montreal, thought there was a tendency to classify all these cases of spasm as tetany. The tetany of Trousseau is very different from ordinary spasm. There are carpo-pedal contractions. It is, like chorea, a term to cover a great number of affections.

Dr. Griffith, in conclusion, said he would be inclined to agree with Dr. Jacobi, if Dr. Meigs had not thought it worth while to report certain cases of laryngismus stridulus in his book. In Philadelphia it is a rare disease. His second case was in a colored child which he saw but once. Dr. Stewart's idea

was what he first thought, but he has investigated and changed his mind. It is not a disease, but a symptom, and when we have a certain group of symptoms, we call them tetany.

Dr. F. P. Kinnicutt, New York, showed blood charts of cases of various kinds of leucocytosis.

Dr. Wharton Sinkler, Philadelphia, then read a paper entitled LEAD PALSY IN CHILDREN. Children are supposed not to be so liable to lead poisoning because they have more active powers of assimilation. It is astonishing there are not more cases of lead poisoning in America when one considered the water drinkers and the lead pipes. The paralysis is both motor and sensory and in the arms in adults; in children it occurs in lower and upper extremities. Drs. J. J. Putnam and H. D. Chapin have reported cases. Cases are reported from eating and sleeping where it is, etc. The lead is eliminated by the bowels and also by the kidneys. Drugs have little influence on it when deposited in the tissues because it is there as a stable compound. Iodide of potash has very little influence over it.

Dr. James J. Putnam, Boston, confirmed the statement that the legs were affected in children as early if not earlier than the arms of adults. He experimented with lead on dogs and found changes in the cord. The greater use of the upper extremities may account for the paralysis there. He does not agree with Dr. Sinkler as to the cause of paralysis in children.

Dr. A. Jacobi, New York, remembered two cases in children in which both arms and legs were equally affected.

Dr. M. Allen Starr, New York, reported two cases of lead poisoning in children, brother and sister, children of a painter. It began in the lower extremities and extended to the hands. They were of short duration. The girl died first and at the autopsy the cord was perfectly normal, but the peripheral nerves were all affected in the distal portion, but the main trunks were apparently normal.

Dr. Charles A. Dana, New York, reported a STUDY OF THE TEMPERATURE IN CEREBRAL APOPLEXY. There is always a rise of temperature after the stroke and then the temperature falls. It may cause unilateral rise of temperature. The close study of the temperature is of great help in the diagnosis and prognosis of apoplexy.

Dr. J. J. Putnam, New York, reported a similar case.

Dr. C. G. Stockton, Buffalo, asked what he meant by the affected side.

Dr. Dana said the paralyzed was usually called the affected side. The temperature is usually higher in the axilla of the affected side than in the axilla of the other side.

Dr. John H. Musser, Philadelphia, then read a paper entitled THE MILD CHARACTER AND DIMINISHED PREVALENCE OF SYPHILIS AND THE INFREQUENCY OF VISCERAL SYPHILIS. He quoted hospital records to prove his point. Syphilis of the present day is of mild type and is infrequent compared to a period of 20 years ago, because the community is becoming immune, because the virus is less active, and because people are cleaner. Internal syphilis is passing away and are we justified in attributing the rarity of nervous syphilis to this fact.

Dr. E. G. Janeway would question the statistics. It is a mistake to ignore syphilis as a factor in the production of disease; it stands in close connection with locomotor ataxia and general paralysis. Quite a number of physicians fail to take up syphilis as a productor of internal diseases of the nervous system, in obscure nervous troubles. In brain tumor we use the iodide of potash with excellent results, and it is a question if we do not have syphilis to deal with here. There are so many cases in which we are doubtful of the diagnosis and the exhibition of anti-syphilitic treatment effects a cure. In numberless ways we find this disease concealed by other symptoms.

Dr. Henry M. Lyman, Chicago, has had an experience quite in accord with that recorded in the paper. He referred to the Hawaiian Islands and the absence of syphilis there and its re-introduction and mild character. He mentioned the almost entire absence of symptoms in

the first and second stages and its mildness generally.

Dr. I. E. Atkinson, Baltimore, thought it was difficult to speak of such paper from impressions, but it is not possible to say that the disease is declining, from observations extending back only 30 years, when the disease is so old and on such slender hospital statistics too.

Dr. Post, Boston, liked the paper. He had much experience in syphilis and some cases get well with no treatment at all, and some with treatment and some will not get well at all. It seems impossible for it to be dying out. Prostitutes spread the disease.

Dr. Frederick C. Shattuck then read a paper on THE SIGNIFICANCE OF ALBUMEN AND CASTS IN THOSE PAST MIDDLE LIFE. The frequency of albumen and casts needs constant study. Albumen and hyaline granular casts can be found in all urine after middle life. It has been said they have no significance. The best test for albumen is heat and nitric acid. It takes time to find casts. They are often overlooked. As age advances cases with albumen and casts increase, with no albumen and no casts, decrease and with albumen alone remain about constant.

Dr. I. N. Danforth, Chicago, agreed with Dr. Shattuck that much care was necessary in examining the urine.

Dr. T. Mitchell Prudden, New York, then read a paper entitled EXPERIMENTAL PHTHISIS IN THE RABBIT WITH FORMATION OF CAVITIES. With this he showed a series of excellent photographs and specimens of rabbits which showed that by inhalation experiments with the tubercle bacillus and the streptococcus, he was able to get cavities in the rabbits' lung, which was not easy to do.

Dr. E. L. Trudeau, Saranac, New York, then read, through Dr. A. L. Loomis, a paper entitled REPORT OF THE ULTIMATE RESULTS OBTAINED ON EXPERIMENTAL EYE TUBERCULOSIS BY TUBERCULIN TREATMENT AND ANTI-TUBERCULAR INOCULATION. He showed as the result of his experiments that the reaction of living tissues to tubercular inoculation can be modified artificially, and thus the production of a relative, and in a few cases apparently complete, artificial immunity is a possibility.

Dr. Norman Bridge, Los Angeles, California, read a paper entitled COUGH AGGRAVATED BY HORIZONTAL POSTURE ON ONE SIDE AS A STRONGLY SUGGESTIVE SYMPTOM OF UNILATERAL TUBERCULOSIS. He attempted to show that a cavity on the side prevented lying on that side until it was far advanced.

FOURTH DAY, JUNE.

Dr. Henry M. Lyman, Chicago, read a paper on GASTRO-ENTERIC RHEUMATISM. He drew the diagnostic points and thought the pathology was not clear. It occurs among neurotic, arthritic, senile and prematurely aged people. Careful diet, with soda bicarbonate, soda salicylate and salad oil, are indicated.

Dr. John H. Musser, Philadelphia, thought that the use of this term was unnecessary and the multiplication of new terms in medicine was to be deprecated. This is not a local affection, but a part of a morbid process in the stomach, kidneys, etc.

Dr. J. E. Graham, Toronto, said if we used this name for this disease, we should change the name of acute articular rheumatism.

Dr. Victor C. Vaughan, Ann Arbor, Michigan, said we should remember that the word rheumatism is used to cover a great variety of things. The pains may be of various kinds and in different places. We ought to make a distinction between these pains when caused by uric acid, and when caused by other things. The etiology is supposed to be imperfect elimination of uric acid.

Dr. Israel Dana, Portland, Maine, thought we should remember that rheumatism was a conglomerate term and there are many forms of it.

Dr. Victor C. Vaughan, Ann Arbor, Michigan, said that a diagnosis should be made by examining the number of polynuclear cells in the blood.

Dr. George Dock, Ann Arbor, Michigan, then reported a CASE OF OSTEOMALACIA. The two theories are, one by Ribbert that it is due to an invasion of bacteria and one by Fehling that it is a trophoneurosis and due to irritation from the ovaries.

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BALTIMORE, JUNE 9, 1894.

Congress of American Physicians and Surgeons.

THE Congress of Physicians and Surgeons, which convened in Washington last week, was in every way a very notable assembly. Fourteen sections of specialists united in forming this body and the records of their work will be looked forward to with interest. The department of most universal interest, perhaps, was the session of American Physicians, whose proceedings are recorded in this number. This association is composed of general practitioners of high standing and wide reputation and their work is worthy of mention. Of particular interest, as is the case in most medical societies, were the discussions. They were spontaneous and facts were presented without that unnecessary padding so characteristic of some long papers. In the consideration of typhoid fever and of typho-malaria, while much matter was worked over and antiquated views resurrected, it is interesting to note the change of opinion on these diseases and the gradual return to some of the former methods of treatment. In the Climatological section, which is closely allied to the Association of Physicians, the subject of tuberculosis and its treatment by food, climate and its prophylaxis generally was of special prominence, and the latest views were ventilated. The proceedings of the entire Congress will be published within the next few weeks and the work will be found worthy of such a distinguished body.

* * *

Sewer Gas.

AT one of the general sessions of the Congress of American Physicians and Surgeons the subject of sewer gas was introduced and the old ideas on the poisonous character of sewer air were completely refuted. The test showed that sewer air does not vary very markedly from the air we ordinarily breathe, except that it contains slightly less oxygen and more carbonic acid gas; and that it contains very few bacteria, which is in strong contrast to what is popularly taught.

Many mistakes in teaching are due to falsely preconceived ideas and vague impressions which have no scientific basis. Sewer air contains few pathogenic bacteria because the non-pathogenic bacteria act antagonistically to them; again, the few bacteria in sewers are kept adherent to the sides of the pipes because of the moisture. Experiments on the pressure of sewer gas would seem to show that there is very little pressure and the flow is almost always toward the mouth of the sewer and not backward, as has so often been affirmed.

Experiments in the laboratory with sewer air and liquids in closed vessels containing bacteria showed that it was very difficult to displace the bacteria from the liquid unless by very strong agitation of the latter and even when active bubbling and effervescence was caused in the liquid, and as sometimes occurs in sewers, very few bacteria were set free. This would prove that even if there were backward currents of air (which rarely occur), they would have to be very much stronger than they usually are to displace bacteria and carry them into buildings and houses.

The effects of sewer gas on children and on the throat were considered. The theory evolved from an old man's brain, that children

having their mouths near the ground were much more liable than adults to inhale bacteria was considered absurd. It was shown that sewer gas does not cause diphtheria but a case of diphtheria may undoubtedly be aggravated by exposure to sewer exhalations, and certain forms of throat disease are made worse by the presence of sewer gas.

The attempts to show the harmlessness of sewer gas were rather extreme and while the work of these scientific papers was not complete, the general inference drawn from them and from the discussions which followed was that sewer gas is hardly more unwholesome than ordinary atmospheric air, and that there was even a tendency to overstep the mark by those speakers whose work was not of an experimental character.

* * *

MEMBERS attending a medical society are much like school boys in their rush to the door at the close of the session and thorough enjoyment of the recess. If there is one part of a medical congress that the members enjoy it is the social feature. The most brilliant paper may attract a large number of hearers, but a dinner, excursion or reception will prove the drawing card and will always have the largest number. Societies have tried the experiment of holding one or two long sessions or several short ones, and the members often find both ways irksome. The short session with an intermission is probably the better, for the most receptive mind wearies after listening to several long papers with their following discussions. Much of the success of these meetings depends on the chairman. If he be a live man he will have plenty of good discussion. Under his quick decisions long papers will be cut short and the discussion kept in motion until each one prizes the opportunity to speak and the writer of the paper feels that he has written for the members present and will not have his good work buried in the printed transactions.

* * *

THE slow and protracted operation is a thing of the past. The motto now is "More haste, more success." The time when two hours and over were taken to perform an operation has gone by and many surgeons now measure their chances of success by the rapidity of the operation. The patient is no longer kept under the influence of an anesthetic for hours and the surgeon and assistants worn out by constant stooping and manipulation. Long operations are often fatal to the patient from shock, from the after-effects of the anesthetic and from infection caused by the long exposure of the open surfaces. Careful preliminary preparation and a surgeon with deft fingers, quick eye and active brain are all necessary for successful latter day surgical operations.

* * *

A FASCINATING young woman in a neighboring State is being sued by her physician to recover the amount of his bill. She alleges that he included his social calls in the list of his professional services, and that she does not want to pay for the privilege, universally conceded to her sex, of making herself agreeable. If her plaint is true, this is the most remarkable case of thrift in the combination of business with pleasure on record. If it is false, doctors will in the future beware of talking with entertaining lady patients on other than professional topics for fear of being compelled to accept this entertainment as part payment. In either case, both professional and society circles have received a solemn warning.

* * *

MAN'S faith in human knowledge is illustrated in the picture of the bald-headed physician prescribing for baldness in a patient. As long as the world lasts people will trust in the power of medical science to restore lost tissue. Plastic surgery may have made great advances of late but neither drugs nor surgical operations can make the hair grow from a dry scalp containing no hair follicles. The less hats are worn, and especially tight-fitting ones, the better the chances for preserving the hair. The toilet of the scalp needs more careful attention and physicians should advise rather how to save the hair than to give useless prescriptions for a hopeless alopecia.

* * *

THE responsibility in attending a case of obstetrics is much heavier than some hospital internes appreciate. It not uncommonly happens that the demonstrator of anatomy in some medical college, wishing to improve his opportunities, is enrolled on the list and takes his turn at delivering some unfortunate woman in the lying-in hospital, who may escape infection but whose chances for puerperal septicemia are much greater than they should be.

MEDICAL ITEMS.

Canada wants a National Bureau of Health.

*

Cholera is still raging in some parts of Russia.

*

Dr. Frank West will go to Deer Park this summer as resident physician.

*

Dr. H. L. E. Johnson is vice-president of the "National Sanitarium" Association.

*

The food inspectors have already condemned some meat and milk as unfit for consumption.

*

There is to be a Section on Medical Journalism at the next International Medical Congress.

*

Mt. Washington, Md., will have the sanitation of the town under the care of the health officer of the county.

*

The Illinois State Medical Society will try to get the Legislature of that State to establish an epileptic colony.

*

A Hospital for Consumptives is to be erected in Philadelphia, to be under the care of the Bureau of Charities and Corrections.

*

Dr. John B. Hamilton, the editor of the *Journal of the American Medical Association*, is said to be a candidate for Congress.

*

Dr. Jeremiah W. Brickley, a well-known physician of York, Pennsylvania, died there last week in the sixtieth year of his age.

*

The University of Pennsylvania has decided to bestow the degree of LL. D. on Dr. William Pepper and to erect a statue to him.

*

Dr. Henry Wickes, of the United States Marine Hospital Service, who has been stationed in Baltimore, has been ordered to New Orleans.

*

Dr. J. Ford Thompson, of Washington, D. C., delivered the address at the Commencement of the Medical Department of Columbian University, of that city.

*

It is said that the Czar of Russia will give fifty thousand roubles towards the expenses of the next International Medical Congress to be held at St. Petersburg.

The medical graduates in Washington, D. C., were Columbia Medical School, 34; National University, 7; Georgetown University, 25: and Howard University, 41.

*

The Collector of Internal Revenue of Maryland has been punishing the retail druggists who are selling liquor on physicians' prescriptions without the proper tax.

*

During the month of May the vaccine physicians of Baltimore performed 24,309 vaccinations. Chicago is using from 60,000 to 100,000 vaccine points a day.

*

The city government of Providence, R. I., has taken the preliminary steps towards the construction of a large and complete filtration plant for its public water works.

*

Dr. Adam Politzer and Dr. Joseph Gruber, of Vienna, otologists of world-wide reputation for many years, have only recently been made ordinary Professors in the University.

*

Mr. Nathan Strauss, that large-hearted New York philanthropist, has opened depots in the tenement-house districts of that city where the poor can buy good sterilized milk at cost.

*

At the meeting of the Consumptive Hospital Organization, last Tuesday, directors and incorporators were elected and the attorney was instructed to take out incorporation papers at once.

*

Drs. S. M. Burnett, T. Morris Murray, William H. Hawkes, H. L. E. Johnson, James Kerr, G. B. Harrison and E. L. Thompson compose the staff of the Central Dispensary and Emergency Hospital, Washington, D. C.

*

The *International Medical Magazine* has passed out of the hands of the Lippincotts. Dr. H. W. Cattell will hereafter edit the journal under the direction of Drs. John Ashhurst, of Philadelphia, and James T. Whittaker, of Cincinnati.

*

Dr. Melvin S. Rosenthal, resident physician, Dr. Jordan Smith, assistant resident physician, and Dr. Albert J. Lacier, visiting dispensary physician, of the Hebrew Hospital, of Baltimore, have been re-elected to those positions.

Book Reviews.

A Manual of Practical Obstetrics. By Edward P. Davis, A. M., M. D., Professor of Obstetrics and Diseases of Infancy in the Philadelphia Polyclinic, etc. Second Edition, Revised and Enlarged. With 134 Illustrations and 16 Full-page Plates, several of which are colored. Philadelphia: P. Blakiston, Son & Co., 1894. Pp. 351. Price, $3.50.

As stated in the title this edition is larger than the former, an account of symphyseotomy and its results having been added, and also additional facts in connection with the practice of palpation and the diagnosis of positions. It is an extremely practical work and the many cuts make it a valuable book for the student.

Treatment of Typhoid Fever. By D. D. Stewart, M. D., Lecturer on Clinical Medicine, Jefferson Medical College, etc. Physician's Leisure Library. Detroit: George S. Davis. Price, 25 cents.

This is a very excellent epitome of what is known at the present time about typhoid fever with its prophylaxis and treatment. The chapter on the general management of a case is particularly good. The author is a strong believer in the Brand method of reducing temperature and has used with success the various forms of naphthol. While he adds nothing to our knowledge of the disease, he has compiled a very readable little book.

REPRINTS, ETC., RECEIVED.

The Perfect Needle-Holder. By Charles P. Noble, M. D.

A New Uterine Curetting Forceps. By Charles P. Noble, M. D.

Pyothorax and its Treatment. By Carl Beck, M. D. Reprint from the *Medical Record.*

Madame Boivin. By Hunter Robb, M. D. Reprint from the *Johns Hopkins Hospital Bulletin.*

Dr. Unna's Plaster-Mulls. By Horatio R. Bigelow, M. D. Reprint from the *Medical News.*

Surgical Clinic. By F. C. Schaefer, of Chicago. Reprint from the *Chicago Clinical Review.*

Procidentia Uteri. By Charles P. Noble, M. D. Read before the Obstetrical Society of Philadelphia.

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PERSISTENT hiccough will often yield to repeated doses of the valerianate of ether.

*

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*

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*

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*

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ORIGINAL ARTICLES.

SOME ACCOUNT OF BARON LARREY,
SURGEON TO THE ARMIES OF FRANCE UNDER NAPOLEON THE FIRST.

READ BEFORE THE JOHNS HOPKINS HOSPITAL HISTORICAL SOCIETY.

By Walter B. Platt, F. R. C. S.,
Baltimore.

HAVING occasion recently to look over some of the writings of Baron Larrey, I found myself so strongly attracted by the man and his work, that I was led to look further. The feeling that his most remarkable and useful career cannot fail to interest all of us who are hero worshipers led me to note a few of his deeds. If this has more of the nature of a chronicle than of a sketch, it is because the limited time and space forbids more than a mention of a few of the acts of his long and honorable life.

Dominique Jean Larrey was born at Baudean, in the south of France, in July, 1766, of parents neither rich nor noble. He began the study of medicine at the age of thirteen years, with an uncle at Toulouse, who was Surgeon-Major and Professor in the City Hospital. It will be noticed that he was three years older than Napoleon. In 1787 he was appointed Surgeon in the Navy, and soon after went on a voyage to Newfoundland on "The Vigilante," which was sent to protect the French fisheries. After making many interesting and valuable observations upon the country, the people, climate and animals (a habit which he subsequently followed wherever he happened to be), he returned to France the year following.

In Paris he diligently attended the hospitals, particularly those of Desault in the Hôtel Dieu, and the Hôtel des Invalides; the affairs of the Bastile and Marsfield affording rich material. Soon leaving the Navy, he joined the Army of the Rhine and went to Germany. It was early in this campaign that he first saw the wounded on the field of battle and he acknowledged the horrible impression it made upon him. Doubtless it was due to this and his strong humane instincts that caused him to then devise the flying ambulance, with which his name will always be connected. At that time it was the custom to attend to the wounded long after the battle was over, at any time within 24 to 36 hours. This was considered unavoidable, one of the unalterable incidents of war.

His way of going counter to established tradition when he knew he was right was further shown in his insisting upon the superiority of immediate amputation upon the field of battle, a superiority which only antiseptic surgery has been able in any degree in our own time to render doubtful. Without antiseptic surgery it is beyond question the better method. In this position he was opposed by Desault and his followers.

At the close of this campaign he was

made Surgeon-in-Chief to the Army in Italy, where he met Bonaparte for the first time. Returning to Paris he married Charlotte Leroux, the daughter of the Minister of Finance under Louis XVI. Some time later, in Catalonia, he treated a number of soldiers who were blown up by the explosion of a mine. In four of these patients he amputated two extremities of each. These all lived, notwithstanding that they were badly burned in addition. Shortly after he was made Professor of Surgery in the Medical School of Val de Grace, where he gave courses in operative surgery.

In Egypt, Larrey made valuable observations upon a great variety of subjects. Indeed, he was fascinated with the country and climate, bitterly lamenting upon his departure that the French were not able to hold it; this in spite of the fact that the army suffered greatly from ophthalmia, scurvy, dysentery, tetanus, thirst and the plague. He describes the terrible wounds made by the sabres of the mamelukes, sings the praises of the climate and dwells upon the healthfulness of the water of the Nile. He attributed the epidemic ophthalmia to the combined influences of the blinding reflection of the sun from the white sand, the fine sand dust in the air, the suppression of perspiration by the cool nights succeeding warm days, and finally to the effects of alcoholic and sexual excesses. In days when bacteria were unknown, this came as near a catalogue of causes as we should be likely to get. This Egyptian ophthalmia gave less and less trouble as time went on, until in the year 1800 the effects were insignificant.

Of over three thousand Frenchmen treated under Larrey's direction, none lost their eyesight. In discussing the comparative merits of local and general depletion he was emphatically in favor of the former. The large number of cases of facial paralysis after returning to France he attributes to the sudden change from a hot to a cooler climate. After a skirmish in October, 1788, many Frenchmen died of tetanus.

He describes the journey across the desert when numbers died of thirst, and the only fuel for the cold nights was obtained by burning the bones of animals who had perished while passing over the same desolate route in previous years. During an ebb-tide the troops with Napoleon crossed the Red Sea on foot, with little difficulty excepting the last contingent, who barely got over safely. It was at the same place where Moses was believed to have crossed, and Napoleon is said to have remarked that it would have given his enemies altogether too good a chance to draw a parallel between himself and Pharaoh, had anything happened to him or his troops.

In the following campaign in Syria, near El Airich, Larrey (to use a Hibernicism) made beef tea of camel's flesh, remarking, with a touch of humor, that it was at any rate better than that made from horse-flesh. On the capture of the place Larrey found it infected with the plague, whereupon he had the premises disinfected, cleaned and the walls whitewashed, after which there was little trouble. But few of the wounded were affected. While besieging Joppa the army were attacked with the plague, in which he had the unhappy opportunity of witnessing the sudden deaths of the victims, who were all affected with genuine blue inguinal swellings.

At the siege of Acre, where thirteen attempts were made to storm the works, the wounded were tormented by the larvæ of blue-bottle flies, which laid their eggs in the wounds. While Larrey thought these maggots disagreeable he believed they hastened healing by disposing of necrotic tissue. There was great difficulty in transporting the wounded on the retreat from Acre; however, by using the horses of the officers not one wounded man was left behind in Syria to the tender mercies of the Turks. The soldiers were now greatly annoyed by hair-like leeches in the water of the pools from which the troops drank. These fastened themselves upon the pharynx and posterior nares, when they swelled to the size of an ordinary leech distended with blood, causing much discomfort.

He describes the horrible execution by the French of the assassin of General

Kleber. The hand which stabbed General Kleber to the heart was first burned off, the victim was then impaled, the stake passing through the kidneys, fracturing several of the vertebræ, and piercing the spinal canal. While suffering great agony the unfortunate man lived for four hours without so much as uttering a groan. Larrey then embalmed the heart of Kleber and sent the skeleton to France. Not long after this syphilis attacked many of the army. Larrey immediately erected hospitals for men and for prostitutes, where such cases were thoroughly treated before being allowed to go at large. In this way he cut short what promised to have a disastrous effect upon the troops. He found syphilis easily amenable to treatment, which was best carried out by warm baths, diaphoretics and mercurials internally. The method by inunction he found ill suited to the climate.

Baron Larrey was immensely impressed with the advantages of the vapor baths of Egypt, so much so that he caused the erection of similar institutions in Paris on his return to France. He became intimately acquainted with a female physician of Cairo, who allowed him to peer through a hole in the wall of her apartments into one of these famous baths frequented by women. What he then saw Larrey evidently considered much in the light of a professional secret, for he reveals little, although he declares he beheld much that was extremely interesting.

Many of the wives of the French officers who had never been pregnant in Europe became so after frequenting the baths. The attendants of these Egyptian baths are most skillful in aiding or preventing conception, procuring abortion, increasing the size of maiden breasts, circumcising girls, and performing many other kindred offices. Larrey tells us that hydrophobia is unknown in Egypt, while small-pox is very common. Inoculation for this disease has been practiced from time immemorial by putting a piece of wool dipped in variolous pus upon the arm of a child. Circumcision is practiced upon girls as well as boys, the former having the labia minora and clitoris removed. Herniotomy, lithotomy and amputation were unknown to Egyptian physicians. At Aboukir, Larrey again noticed the superiority of immediate field amputation over later operation. About this time there was a terrible epidemic of scurvy in Alexandria. Upon the surrender of Cairo, the English gave the French fresh provisions and wine, which brought about a speedy cure. Returning to Paris, the French government gave Larrey a present of 15,000 francs, thanking him at the same time for his services, and he received a decoration from the hands of Napoleon.

While in Egypt, Larrey established a school for instruction in military surgery and taught it in person. This was in addition to hospital work, where he constantly not only did his duty, but much more than his duty. He interested himself, moreover, in anthropology, despoiling many mummies of their heads, in order to compare them with the skulls of recently interred Copts to determine the vexed question of the identity of this race with the ancient Egyptians. He gave an accurate description of the scurvy and noted the good effects of acidulated drinks. He discusses the Egyptian method of embalming, finding three series of mummies differently prepared, and finally prefers his own way as superior to the ancient, for he often had occasion to send back to France the bodies of prominent officers. He describes the learning of the midwives, as well as their lack of it. The woman about to be confined sits in a chair firmly held on either side until the child is born, the result of the whole being a ruptured perineum with tolerable regularity.

Even the winds of Egypt do not escape him and their influence upon the sick and wounded is noted. Larrey believed in the climate as thoroughly as a native or recent convert of the State of Colorado, saying that of natives in easy circumstances in Cairo, thirty-five were one hundred years of age. Elephantiasis of the scrotum attracted his attention. He mentions two of immense size. He observes how frequently he had recovery after wounds of the sigmoid flexure

without a resulting fistula. In one case of wound of the ileum, the intestine being completely divided, he stitched the ends to the wound and the man recovered. Certainly his men did well. He mentions the case of a Hussar who received seven extensive sabre wounds, some of these severing bone as well as muscle, besides a bullet in the thorax, which was followed by empyema, in spite of which the man made an excellent recovery. Penetrating wounds of the thorax he treated by immediate closure, and notes the better result than by the open method of treatment.

Of one series of nineteen amputations at the shoulder joint thirteen lived, a great degree of success for field work without anesthetics. This is the operation with which Larrey's name is to-day chiefly associated. On arriving in Epypt he treated Napoleon himself for a severe contusion of the thigh occasioned by the kick of a horse. At first the troops suffered much from diarrhea and dysentery occasioned by excess in eating melons, and the cold nights, and not from the water of the Nile, which he asserted was healthful.

Larrey was a cosmopolitan, decried no nationality as a whole; on the contrary, often praised the good points of foreigners. This was especially true of the Germans, whose warm hearts and hospitality he never tired of praising. Indeed, he was what the Germans themselves call a "Menschenfreund." When the Spaniards were accused of drugging the wine given to the French soldiers, as well as of bringing and introducing them to syphilitic women, Larrey said plainly that he did not believe them capable of such a thing.

The Army of France appears to have suffered sadly from syphilis wherever they went, whether in Egypt, Spain, Austria or Germany. In Spain, Larrey was taken ill from privation and fatigue. At the close of the Austrian Campaign he received the title of Baron and 5000 francs.

On the march to Russia, Larrey stopped at Berlin, where he met many noted surgeons and gave instruction to his army surgeons. The soldiers here suffered with syphilis, while not a few were suffocated by carbonic oxide in trying to get warmth out of the German stoves. The use of schnapps lowered their vigor further so much, that when the march to Russia was actually begun they were in poor condition to withstand ordinary privations, much less such as they were about to undergo. Many died from schnapps excess alone. Surgical supplies were so scarce that the surgeons used their own shirts to dress the wounded on several occasions. At one time 10,000 wounded were in the hospital at Smolensk to be cared for. After such exertions Larrey suffered with constant vertigo to such an extent that he kept his feet with difficulty. Yet very soon after this he did 200 amputations in twenty-four hours.

Near Osterode some of his troops were affected with malignant pustule, which he attributed to lying upon swampy ground and to the use of bad meat. The rest of the Russian Campaign is one recital of horrors. We need only speak of the intense sufferings from cold and one or two incidents more immediately connected with medicine. On November 4, the mercury fell to 11° below zero, again to 15° below zero, when there was not a human habitation for twenty-four leagues. Early in December the mercury went as low as 29° below zero, and finally to 31° below, when the entire army, without exception, was compelled to bivouac. Large numbers, of course, perished, while a large percentage of the remainder had frozen feet. Larrey himself says, "Although I was one of the strongest men in the army I could hardly reach Wilna."

Larrey here digresses to mention the sight of a brilliant comet which appeared about this time, and to compare the endurance of the different races of men in the army, believing that the dark-haired natives of southern Europe stood privation and fatigue better than the fair-haired Germans or English. In this connection we must not forget that Larrey himself came from the south of France. When he reached Leipzig, something very much like the grippe was raging which they called catarrhal fever.

Larrey made an amusing mistake in Saxony when he noticed the remarkable attire of the hospital attendants. He calls attention to the fact which he is unable to explain, that their stockings were one half yellow, the other half brown-violet; the truth being that these men were convicts. In Dresden he had an animated discussion with the German surgeons who persisted in sewing their wound flaps tightly together instead of keeping them in apposition with sutures of less tension. Here he again noticed the great numbers dying of tetanus, and the sudden cessation of mortality when the difference between the day and night temperature became less.

At this time Larrey was called upon to defend the soldiers from the charge of self-mutilation to avoid military duty, and succeeded in vindicating his men by proving that among the younger men there were veterans whose bravery was beyond reproach.

Dr. Agnew, in an address to his students in 1861, gives many interesting details of Baron Larrey. He mentions the fact that while in Mainz he attended Sömmering's lectures, and here he invented the lance-pointed needle with the eye in the point. Larrey was several times wounded in his various campaigns; once in the leg in the Rhine Campaign, again, and finally, at Waterloo, where in trying to escape through a troop of Prussians, he fired both pistols, broke his way through, and might have escaped if his horse had not fallen, when he at once received a double wound on the head and shoulder. Believing him dead, they pursued his servants. Larrey shortly afterward arose and walked several miles before he was recaptured. At first he was believed to be Napoleon himself. When the mistake was discovered, it was decided best to shoot him, when a young German surgeon, who recnized him, saved his life with some difficulty. Shortly afterward he was seen by Gen. Bülow, who gave him his liberty and sent him to Blücher. At this time he was barefooted, his hands were bound behind him, and his head covered with bloody bandages. Blücher let him go and gave him the means to return home. As a friend of Napoleon he found few influential friends in Paris, his pension discontinued and himself in financial straits. His pension was, however, soon restored, and in 1826 he was made Surgeon in Chief and Inspector General.

When passing through the south of France in 1834 he was recognized by the soldiers of the Old Guard, one-legged and one-armed remnants of Napoleon's campaigns, who surrounded and followed him from village to village.

Stromeyer says of Larrey, "Napoleon knew how to choose his followers from among those whom the people loved. There was among them scarcely one whose character shines with as pure a light as Larrey's. As a military surgeon, he had an experience no one ever before had, nor will, we trust, ever have again. No surgeon will ever have the opportunity of passing through 24 campaigns, few will ever know how to make their experience and observation of such scientific value as he, in monographs and clinical lectures. The operations devised by him are so simple and appropriate that they will never be given up. His mortality after amputations of the thigh is the least of any surgeon up to this time. His discovery of the great importance of early amputation would alone make his name immortal.

"In 1828, Larrey was a ruin, but as indestructible as the obelisk of Luxor, which is the same as when re-erected from the sands of a thousand years. I could never see him without emotion as he went to and from his clinic in Val de Grace. He was of small stature, with earnest but gentle dark eyes, below a massive brow. His complexion showed the influence of wind and weather, and his whole aspect was made picturesque by the long black hair which fell upon his shoulders."

Dr. Agnew, in his excellent lecture upon Baron Larrey, tells us that he was a little obese, with a head well set upon his shoulders. His skull is said to measure 590 millimeters around, exactly the same as Napoleon's.

Upon the abdication in 1814, Larrey wrote, "I consider myself happy if I can still be useful to my country."

When Napoleon again took the field, Larrey went with his chief to Waterloo.

One of Larrey's devices was that of introducing a gum elastic tube into the tunica vaginalis after tapping, to promote a radical cure.

In the last year of his life he was still full of industry, and begged permission of the government to go to Algiers to inspect the hospitals there. While in that country he was attacked with a congestion of the lungs, and died immediately after reaching Lyons. His death occurred a few hours after that of his wife, who was exceedingly ill when he arrived.

Napoleon said of him, "Larrey is the most honest man I ever have known;" and again, "If France ever wishes to erect a monument out of gratitude, let it be to Larrey."

HEMATOMA OF THE OVARY.

Read before the Gynecological and Obstetrical Society of Baltimore.

By George H. Rohé, M. D.,

Catonsville, Md.

Abdominal surgeons not infrequently find, in extirpated ovaries, small blood clots, varying in size from a pea to a hazel nut. The nature of these clots seems not very clearly understood. In most cases they are believed to be due to excessive hemorrhage into the Graafian follicle after rupture, and the escape of the ovule. This view seems to me not tenable because in not a few instances no rupture of the follicle has occurred. Besides, the corpus luteum, the successor of the ovule in the occupancy of the Graafian follicle, frequently contains no blood. Indeed, the view seems not irrational that hematoma of the ovary, no matter how small it may be, should always be regarded as a pathological formation, having no essential connection with the physiological process of ovulation. In such a specimen as that here shown, in which the blood-clot in the fresh state of the specimen was as large as a small chestnut, we have to deal with a pathological condition. The specimen is from a case of hystero-epilepsy of over eight years' duration in which both ovaries and tubes were removed by abdominal section in 1891. The patient recovered, and has had no recurrence of the epileptic attacks for over two years. Ovaries presenting this appearance are not rarely seen in abdominal section. I am informed that some surgeons simply extirpate the hematoma, stitch up the wound in the ovary, and drop the organ back into the pelvis. I may be permitted to express doubt whether any good purpose is served by this so-called "conservative" surgery. In all cases of this kind that have come under my notice, there were either adhesions or displacements of the ovaries, which are among the recognized indications for removal of these organs. Dr. B. F. Baer, who is known as a very careful and conservative surgeon, says in reference to these cases:* "Diseased ovaries, when due to hemorrhage into the Graafian follicles to such an extent as to produce the condition known as ovarian hematoma, should be removed. They cause intense suffering and there is no other means of relief."

Dr. Mary A. Dixon Jones, of Brooklyn, and Dr. Francis Foerster are of the opinion that hematoma of the ovary is preceded by conditions termed by them "Gyroma" and "Endothelioma." Indeed, the latter writer, basing his opinion upon somewhat extended microscopical study of ovaries, normal and pathological, claims that "what previously was called a corpus luteum is invariably an endothelioma." That the corpus luteum is an endothelial structure may be accepted without dispute; that it should be called by a name heretofore applied to a malignant new formation, or that the consequences attributed by

Foerster to this body hitherto considered so innocent, really follow in many cases, is, I think, open to grave doubt. Chronic oöphoritis and peri-oöphoritis, endarteritis and sclerosis are mentioned as histological findings, and pain and distress as clinical manifestations due to ovaries undergoing these morbid changes.

Dr. Foerster connects the corpora lutea with the production of hematoma as follows: "In my own experience a large number of so-called corpora lutea of menstruation are endotheliomata of a pathological type. They grow under the influence of a chronic oöphoritis without coming to a typical end, or gradually increasing in bulk and frequently leading to the formation of hematoma under incessant local and constitutional trouble.

It will, I think, be generally conceded that a hemorrhage into an ovarian follicle, or into ovarian stroma, does not take place when the ovary or the blood-vessels preserve their normal structural integrity. Some nutritional change must have preceded the hemorrhage. It is most reasonable to believe that this change is in the blood-vessels of the ovary. Whether this nutritional disturbance is due to new formations properly dignified by the names "gyroma" and "endothelioma," or whether it is simply the result of chronic inflammation, is a question that must be referred to the pathologists for further investigation. Rollin,† who has recently made a study of ovarian hematoma, gives chronic oöphoritis as a local condition antedating the hemorrhage.

While the occurrence of small collections of blood in the Graafian follicles and minute extravasations in the ovarian stroma is not infrequent, the cases of so-called ovarian apoplexy, where the entire ovary is converted into a blood-cyst, varying from a billiard-ball to a fetal head in size, are much more rare. The case presently to be related shows, however, that there is no essential difference between the two classes of cases.

The case referred to is as follows:

E. L., born in United States, white, aged 21 years, single, was admitted to the Maryland Hospital for the Insane, November 18, 1893. Until a month before admission there had been no mental disturbance beyond hysterical attacks of varying severity, sometimes accompanied by convulsions. Her disposition was usually amiable, although she was of rather unstable temper. Her habits were always industrious. So far as was ascertained there was no hereditary predisposition to insanity. The hysterical outbreaks were usually coincident with the menstrual periods, and have only been present for the past four or five years. Up to a year ago her physical condition was very good, but for three years she has suffered with a good deal of pain during the catamenia. About a year ago she consulted a gynecologist, under whose care she remained for several months with apparent improvement. During the last three or four weeks before admission, a great change in her behavior was noticed. She became exalted, talkative, silly in conversation and action. When admitted, she carried a large doll, which she caressed and talked to in a childish manner. She was neat and cleanly in dress and habits and never noisy or maniacal. No apparent sexual excitement. At the end of two weeks she had lost all her delusions and was apparently restored to her normal mental condition. At the approach of the next menstrual period she became hysterical, had several convulsions, foamed at the mouth, screamed, or lay with eyes staring or closed. Reflexes normal. During these attacks she was unquestionably conscious of what was going on around her. One evening she set fire to her clothing, but the fire was promptly extinguished, and only a slight superficial reddening of small areas of the skin was produced. No serious results followed this attempt at self-destruction.

After the period was over, her normal mental condition returned but she did not improve physically. She lost appetite, had nausea, and became thin and anemic.

The pains in the iliac region persisted and became especially severe on the left side. Occipital headache, rhachialgia and pains in the limbs, with attacks of

nausea and vomiting, were also present.

On January 18, 1894, a vaginal examination demonstrated an elastic swelling behind and to the left of the uterus, which was exquisitely sensitive to the touch. To the right there appeared to be an enlarged and prolapsed ovary. The uterus was adherent posteriorly, but somewhat movable.

The clinical diagnosis of adherent uterus, prolapsed ovary on the right and cystic ovary or ovarian abscess on the left side was made, and an operation for the relief of these conditions recommended to her, and her consent readily obtained. Inasmuch as she was, and had been for some weeks, entirely rational, her own consent was considered sufficient authority to proceed.

Abdominal section was done on January 28, 1894. Passing two fingers through the incision down to the fundus, this was found adherent, the tubes and ovaries on both sides being also bound down by adhesions. After carefully separating the latter, the right ovary, enlarged to the size of an English walnut, was brought up, ligated together with the thickened tube close to the uterus, and removed. In place of the left ovary was a cystic tumor as large as a mandarin orange, which ruptured as it was brought out of the abdominal wound, and discharged a lot of softly-coagulated blood. My first thought was of an ectopic pregnancy, but as an examination of the specimen will show this was a mistake and an unjust suspicion. After the tube and remains of the cyst were ligated and removed, the peritoneal cavity was flushed out with hot, distilled water, and the abdominal wound closed with silk-worm gut sutures. No drainage.

The subsequent course was uneventful, except that on the second day the temperature rose to 101 degrees F., and the pulse to 102. After a purgative enema of magnesium sulphate and glycerine, this slight disturbance vanished.

The stitches were removed on the seventh day and the wound was found dry and thoroughly united. Patient out of bed on the 21st day.

Since the operation the patient has suffered no pain, is cheerful and industrious, not hysterical and has gained flesh. Her mental condition apparently normal. The patient was discharged entirely recovered March 15, 1894.

The walls of the blood cyst are apparently composed of ovarian stroma; the tube is somewhat thickened, but contains no pus. The right ovary, on section, shows two blood-clots about the size of hazel nuts, apparently occupying unruptured Graafian follicles. This case seems to show, on the two sides, examples of two forms of ovarian hematoma which are however rarely associated in the same individual. If any conclusion can be drawn from a single case, it is that the rather common follicular hematoma and the infrequent ovarian apoplexy are identical in origin.

Winckel‡ refers to three cases of follicular hemorrhage into the ovaries after severe burns. The burn which my patient received about a month before the operation might be considered suggestive, if it had been more serious. The firm adhesions were, however, evidence of a longer duration, at least of the local inflammatory condition.

Of the more recent cases reported, is one by Doran in Vol. 32 of the Transactions of the London Obstetrical Society. Doran considered it a hemorrhage into the ovarian stroma from rupture of a follicle. The cyst wall was one-eighth of an inch thick and consisted of ovarian stroma. Dr. Mundé§ briefly reports a case of hematoma of both ovaries, one being the size of an orange and the other of a hen's egg. Dr. E. E. Montgomery,‖ in commenting on this case, refers to a similar one under his observation. Duncan¶ reports a case in which there was hematosalpinx in connection with the ovarian hematoma. The history of the case suggests ectopic pregnancy, which seems, however, to have been excluded.

I am reminded here of a case which I saw about twelve years ago in the service of the late Dr. A. F. Erich at the Maryland Woman's Hospital. The patient was a white, single woman 35 years of age. The tumor, supposed to

be an ovarian cystoma, was about the size of a fetal head and when brought to the abdominal incision and tapped with the trocar, thick, black blood was evacuated. The patient died of purulent peritonitis about the fifth day, and at the autopsy a perforation of the rectum was found. How this was produced could not be cleared up. It may have been torn through in separating adhesions. A number of apparently similar cases, in which the cyst ruptured and caused death from septic peritonitis, are recorded by Bernutz and Goupil, but most of these were probably cases of extra-uterine pregnancy.

An ovarian hematoma may rupture and give rise to a pelvic hematocele. In other cases the bleeding may continue and the patient die of hemorrhage. The most serious danger from rupture is, however, peritonitis and sepsis. I am informed by Dr. Joseph Price that the contents of an ovarian hematoma are usually exceedingly virulent and liable to cause septic peritonitis, if the blood-cyst is allowed to rupture within the peritoneal cavity.

The diagnosis of ovarian hematoma can not be definitely made before abdominal section. Even when rupture occurs and a hematocele is formed, the diagnosis rests between several conditions, often differentiated with the greatest difficulty, even after operation.

The only rationally indicated procedure is removal of the affected organ by abdominal section.

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‖Ibid, 1893, II, G. 5.

A CASE OF ASCITIC DISTENTION OF THE ABDOMEN MISTAKEN FOR PREGNANCY.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, MAY 9, 1894.

By T. Ridgway Barker, M. D.,
Philadelphia.

THE following case is reported in order to prove the importance, if not absolute necessity, of making a careful and thorough examination of all women pregnant, or supposed to be, before committing ourselves to a positive diagnosis.

In June, 1891, I first saw the patient, Mrs. M. N.; she was then eighteen years of age, white, mother of two children. There was no history of any miscarriages. Her general health was good and condition favorable for the development of the product of conception, which she believed was present, menstruation having ceased in October of the preceding year. Inquiry elicited the fact that her menstrual flow up to that time had been perfectly regular and unaccompanied by pain. Morning sickness proved very annoying for the first three months, but later passed away.

From inspection, abdominal palpation, and digital vaginal examination, the patient was judged to be some six months pregnant, and the date of confinement set for the early part of August. On July 27, I confined Mrs. N., delivering her of a fine male infant, which presented by the vertex.

Labor was accomplished without incident or difficulty, and the lying-in period presented no symptoms suggestive of any organic lesion of the kidney. In fact, it is fair to assume that at that time there did not exist any disease of that excretory organ.

The puerperant's pulse was 72 immediately after delivery, but the temperature was not taken.

I visited Mrs. N. for ten days, when attendance was discontinued, the patient being able to be up and move about her room. Mrs. N. was not seen again by me for over two years, when she called at the dispensary and stated that in the first week in January, 1893, she had suffered from a miscarriage.

The product of conception she passed she presumed was about three months gestation. The cause of its expulsion I was unable to determine, but ascribed it to a catarrhal condition of the endometrium.

While carrying the embryo she had a slight flow of blood each month, which she imagined was her menstrual flow, though she remarked at the time it was of shorter duration and more scanty than usual.

The patient failed to return on the day specified and was not seen again until March 6, of this year. She stated on presenting herself at the clinic that some months after her last visit to the institution she imagined herself to be in the family way again and called to see a physician. The doctor, she reported, told her that he believed her view to be correct as to her condition, and that he considered her about four months pregnant, and that her confinement might be expected in December. No vaginal examination was made by him, however, nor did he palpate the abdomen, but based his diagnosis simply upon the results of inspection of the uncovered ventral region.

The breasts were exposed on this occasion and were found to be large, full and globular. The veins were prominent and the areolæ well defined. Milk on pressure, she stated, exuded from the nipples as in former pregnancies. At this time her feet were considerably swollen and the edema tended to extend up the limbs.

Morning sickness was entirely absent. Leucorrhea was present, but no remedies were directed toward its treatment. At each monthly period, the patient stated, she had a scanty flow of blood, but thought nothing of it as she had much the same discharge in a former pregnancy. She did not again call on her physician, as she felt no anxiety, having passed through three confinements without difficulty.

When I saw Mrs. N. it was March 6, nearly three months, I learned, after the date of her expected confinement. She was then suffering from nervous prostration incident in a large measure to the worry occasioned by her delayed labor, as she was afraid something was the matter.

Her abdomen, she stated, felt different from what it had ever done before. Inspection of the breasts showed them to present what one might almost say was a condition typical of pregnancy. Even the colostrum exuded on pressure from the orifices of the lactiferous ducts. On inquiry as to whether she felt fetal movements, she replied that she did at times, but very slightly. No bearing-down sensations, however, or pain had been experienced.

A glance at her abdomen showed markedly that it was not as prominent as one would have reason to expect it would be in a multipara at full term.

On request, Mrs. N. consented to lie down on the sofa in the dorso-recumbent position and as she proceeded to do so I was impressed with the fact that the abdomen at once became flattened and broader. This made me suspicious as to the presence of a fetus and I at once proceeded to palpate over the region of the supposed pregnant uterus. The abdominal walls were flabby and the intestines were in contact with them in front but not on the sides. Carrying the examining hand downward toward the pubis I found the uterus wholly within the true pelvic cavity. It seemed about normal in size and there was elicited no sense of tenderness.

Evidently there was no full-term fetus in that woman's abdomen. Having secured the patient's consent to a digital vaginal examination, I proceeded to make the same, subject to the rules of asepsis. Inspection of the external genitalia presented nothing characteristic. Passing my index finger up the vaginal canal to the cervix, I found it to be elongated, hard, and fissured. The os was small and from it could be felt escaping a mucous discharge. A sound was passed into the uterus and its cavity made out to measure some three to three and one-half inches.

Search for shreds of membrane or other products of a late conception failed to be productive of any result. The distention of the abdomen was undoubt-

edly ascitic and not due to a natural growth of a pregnant uterus.

Further inquiry disclosed the fact that not only had there been for several months edema of the lower extremities, but also swelling of the face as well. This was especially noticeable about the eyelids.

The urine was passed in large quantities and very frequently. It was of a pale yellow or lemon color; specific gravity 1010; of acid reaction. No albumen present. Sediment composed of mucus. There had been for many months a gradual but none the less persistent loss of flesh.

The eyesight was very poor, so much so that the woman could scarcely read the newspapers. A kind of mist, as Mrs. N. expressed it, floated before her eyes. Headache was not a troublesome symptom, nor was any amount of pain referable to the loins made out. Sleep was troubled and the patient not infrequently awoke in a fright.

Inquiry as to the health of her parents brought forth the statement that her father died, under forty years of age, suddenly in the street, and that he had for some years suffered from dropsy. Her mother was still living and enjoyed the best of health. Mrs. N. has no brothers or sisters. It is not my purpose in this paper to enter into a discussion as to the nature of the kidney lesion, but to lay special stress upon the error in diagnosis which resulted simply from a failure to appreciate and apply the golden rules of obstetrics governing the diagnosis of pregnancy. Had the first practitioner who saw this woman not limited his examination to the breasts, but extended it to the abdomen and supplemented the same by a digital vaginal one, he would not have fallen into the error of diagnosticating a case of kidney disease with ascites one of pregnancy.

This case is a typical example of a "snap" diagnosis and only too clearly proves that the thorough way, which calls for inspection, palpation, auscultation, and digital vaginal examination, though more disagreeable, less brilliant, and tedious, is the only safe and satisfactory one in the long run.

Moreover, we see how little dependence is to be placed upon the patient's statements as to her subjective symptoms. Mrs. N. unhesitatingly told me that she did feel fetal movements, though they were slight, on the occasion of my first visit, three months after the date fixed for her confinement.

Examination, however, proved her sensations to be purely imaginary. She believed herself pregnant, and therefore, knowing that she should have "quickened," she believed that she did recognize fetal movements.

While the mistake in diagnosis in this case did not result disastrously, yet it might under some circumstances have been made the basis of a suit for damages.

One may occasionally make some brilliant "snap diagnoses," but he may rest assured disaster will surely follow if this course is pursued for any length of time.

SOCIETY REPORTS.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF MARYLAND.

62nd REGULAR MEETING.

Dr. George H. Rohé read a paper on HEMATOMA OF THE OVARY. (Page 164.)

Dr. Ashby: I have had some specimens of marked hematoma of the ovary. Clinically, these patients complain of much more pain than from other diseases. Most of these cases have been complicated with pelvic peritonitis. If the clinical history indicated violent dysmenorrhea the ovaries should be removed.

Dr. Neale asked if it be necessary to remove the organ for these small clots.

Dr. William S. Gardner: I wish to notice briefly a few points, concerning which Dr. Rohé makes statements that are at variance with what I believe.

In speaking of the pathology of hematoma the essayist presumes that they are caused by diseased blood-vessels, but admits that reliable pathologists have not settled this as a fact. Nevertheless,

he proceeds as if it were a fact and advocates the complete removal of all ovaries that have even a small hematoma in them. In this he ignores some of the best work of the last six years. Martin alone has done twenty-seven operations, in which, after completely removing one ovary, he resected the other ovary on account of small cysts or hematomæ. Twenty-four of these patients were completely cured without further treatment; they did not have to suffer the torments of the artificial menopause; they did not lose their sexual feeling; they were not rendered sterile; eight of the twenty-four bore children.

In another place Dr. Rohé makes the statement that hematomæ are frequently found associated with "adhesions or displacements of the ovaries, which are among the recognized indications for removal of these organs." These statements are both true. But "recognized indications" are not necessarily correct indications; if they were, all progress would stop. Polk has demonstrated beyond a doubt that these cases can be cured without the removal of the appendages. By Polk's method are these patients not only relieved of their pain, but they retain all their functions as women.

I do not wish to be understood as objecting to the removal of ovaries hopelessly disorganized either by hematoma or other process of disease, but it should be remembered that, according to the testimony of Goodell, Glavaecke, Keith and many other authorities, the complete removal of the ovaries not only does *not* cure many cases of mental diseases, but that it actually causes a considerable number. Frequent as are these mental disturbances, they are among the minor evils resulting from the complete loss of both ovaries. The loss of sexual sense, the loss of the possibility of reproduction, and the multitude of discomforts of the artificial menopause, combines to make the life of many of these patients utterly miserable. I have upon my records the histories of patients operated upon by almost every operator in this city, who have come to me with the complaints of their post-operative condition; and only too many of these patients have said that if they had known what they would have to suffer they would have preferred to keep both their ovaries and their pains. I make these statements only to remind those gentlemen who seem to forget it that when a woman's ovaries are removed she is not yet freed from all the ills that may burden her existence.

WILLIAM S. GARDNER, M. D.,
Secretary.

MEDICAL PROGRESS.

HYPODERMIC INJECTIONS OF NUCLEIN. —Dr. Victor C. Vaughan, who in common with other investigators has been testing the efficacy of the hypodermic injection of nuclein solutions in pneumonia, tuberculosis, etc., records his results in the *Journal of the American Medical Association*, as follows :

1. The subcutaneous injection of nuclein increases the number of white blood corpuscles.

2. This increase occurs in both healthy and tuberculous persons.

3. With like quantities of nuclein injected, the increase varies with the person. It may be slight, and it may be three-fold.

4. This increase occurs principally in the polynuclear cells.

It is evident as a rule as soon as the third hour after treatment and generally disappears after the forty-eighth hour.

If the nuclein shall prove of any value in the treatment of tuberculosis, it will most probably be due to the fact that they increase the polynuclear white corpuscles.

I have been using nuclein in the treatment of tuberculosis in man since May 1, 1893. At first I employed only yeast nuclein, but now I am using spleen nuclein in some cases. When sufficient evidence has been obtained either to reject or recommend the treatment, the results will be communicated to the profession. I may say, however, that only in initial cases may we expect any bene-

fit, and even in regard to these I must have more abundant material and a longer experience before I can speak with any certainty.

* * *

COUGHING-TAXIS.—In the *Lancet*, January 27, Dr. Wherry, University Lecturer on Surgery, Cambridge, declares that he has frequently found that coughing on the part of the patient during taxis was a great aid in reduction of hernia. He cites one instance in which after two physicians, aided by chloroform, had failed to reduce, he succeeded by gentle taxis continued for fifteen minutes while the patient coughed continuously. It was a femoral hernia, severely strangulated, in a middle-aged woman.

* * *

CANCER MORTALITY IN GREAT BRITAIN.—A discussion of cancer mortality in Great Britain presented in the pages of recent *Lancets* seems to show that the apparent increase of late years in cancer mortality may be ascribed wholly or partly to greater accuracy of diagnosis in cases where the cancer is not easily reached.

* * *

THE BACTERIOLOGY OF PYELONEPHRITIS.—In connection with Dr. Keyes' paper on Nephritis from a Surgical Aspect, it is interesting to note the conclusions of Dr. George M. Sternberg, Surgeon-General U. S. A., as mentioned in the *American Journal of the Medical Sciences*. He concludes his paper with these words: "Finally, I think we are justified in concluding that cystitis and ascending pyelonephritis are usually caused by micro-organisms introduced through the urethra into a bladder which is rendered susceptible to infection by mechanical violence or chemical irritation. And that the most frequent cause of such local infection is the bacillus coli communis, which is constantly present in the intestine and upon the external surface in the vicinity of the anus, from whence it may easily be transported to the interior of the bladder by catheters, etc., used by the patients themselves or by their medical attendants. According to Bouchard, it has been shown that this bacillus is sometimes found under the prepuce and about the vulva of healthy persons, and this is what we should expect from their proximity to surfaces which are constantly soiled with discharges containing it. But there is no evidence that the bladder is reached by the direct invasion of this or other bacteria without mechanical assistance. The researches of Lustgarten and of Mannaberg and of Krogius show that the bacillus coli communis is not found in the normal urethra."

* * *

THE INFLUENCE OF ALCOHOL, GLYCERINE AND OLIVE OIL ON THE ACTION OF DISINFECTANTS.—Lenti summarizes in the *British Medical Journal* the results of a series of researches as follows: (1) Alcohol in the absence of water neutralizes all bactericidal power on the part of sublimate or phenol with regard to anthrax spores, and the bactericidal action is not exercised until the dilution of the alcohol with water becomes greater than two per cent. in the case of 1 in 1000 sublimate solution, or than seventy per cent. in the case of carbolic acid. The length of time to which the spores were subjected to the action of the solutions was twenty-four hours in the case of sublimate, and forty-eight hours in that of phenol. (2) Glycerine has a similar impeding action, interfering with the action even of a 2 in 1000 solution of sublimate, if the proportion of water be less than forty per cent. In the case of phenol it is still more manifest. (3) Phenol and lysol dissolved in olive oil have no disinfectant action when tested as above. (4) In the preparation of a disinfecting fluid one ought, therefore, to avoid the addition either of alcohol, glycerine or fats.

* * *

THE NECESSITY FOR A WELL-PAID MEDICAL PROFESSION.—In an address before the Southwest London Medical Society Mr. Thomas Bryant urged the importance of physicians being well paid for their services. His remarks have been widely copied and they are well worthy of careful perusal. He said:

"Let us never forget that our patients' interests are those we should always

primarily consider, and that in all our practical and scientific professional work the public good is its ultimate object; but at the same time let us bear in mind that in order to realize this leading purpose it is all important for the interests of the public, as well as for the due exercise and dignity of our profession, that every practitioner of medicine should hold a perfectly independent but responsible position, and that in his professional work he should be left perfectly free from lay control, although amenable to lay censure. It is also equally necessary that he should be adequately paid for his professional services by all classes according to their means. Under these circumstances all measures, whether under the guise of charity or called "provident," and all hospitals, general, special, or private, which encourage the public to seek professional advice for little or nothing, are to be discouraged as helping to pauperize and degrade the public at large; and all members of our profession who induce or tempt the public so to do by means of private hospitals, competing private dispensaries, touting clubs and associations, or who are ready to accept at a reduced figure, over the heads of their neighbors, appointments which have been put up by laymen, as it were, to auction or competition, adopt the surest means within their power to lower the position of their profession in the estimation of the public, and at the same time do injustice to the profession and public by not giving to the latter the best services the former can supply, whilst they must, in addition, lose their own self-respect, even if they happen to gain cash by their unworthy actions. For let me ask, "How is it possible for a man who is ill-paid or overworked, or both, either to give, in the interests of the public, the professional attention it is essential for him to bestow on every case he has undertaken to attend; or to maintain, in the interests of the profession, the position to which he is entitled and his own self-respect? We all know that any measure which encourages, either in a profession or trade, underpay and overwork, leads to bad work. In our profession such deficiencies are no less harmful—nay, they are more so, as its issues to the patient are either life or death, health or ill-health, and to the profession either a position of pleasure, honor and respect, or one of degradation and unrequited labor."

* * *

Intestinal Approximation.—In an article in the New York *Medical Record* on this subject, Dr. J. B. Murphy records a long number of cases and draws the following conclusions:

1. The more rapidly the operation is performed, the less the danger from shock.

2. The less the manipulation and exposure of the intestine, the less the danger of infection, post-operative paralysis, and adhesions.

3. The more uniform and continuous the pressure at approximation, the greater the assurance of adhesion and the less the liability of infiltration.

4. A line of approximation is as good as half an inch.

5. Mechanical means in the last five years have produced better results than the suture, in both lateral and end-to-end approximations.

6. The mortality in end-to-end approximations is much less than in lateral apposition, and should always be given the preference.

7. The more perfect the juxtaposition of the various layers, the less the interposition of fibrous tissue, and the more complete the regeneration across the line of union.

8. The juxtaposition of the similar histological layers of the wall of the intestine is an assurance against cicatricial contraction.

9. The more extensive the approximation surface, the larger the fibrous deposit, the greater the contraction.

10. The contraction with end-to-end is less than with lateral approximation.

* * *

The Non-Alcoholic Treatment of Typhoid Fever.—The London *Lancet* records a report by Sir Benjamin W. Richardson on the Treatment of Enteric Fever without Alcohol in the London Temperance Hospital. The cases treated from 1873, when the hospital was

founded, to 1893, were 144; twenty-five proved fatal, but four of these were moribund on admission. Excluding these we have a mortality of 14.5. Sir B. W. Richardson admits that this success is not enough to establish the superiority of the treatment, and, indeed, compares indifferently with that of some other hospital returns. But the great value of the paper is in its extreme fairness and in the care, which the writer shows to be necessary before coming to hasty conclusions on this subject. He properly insists not only on the necessity of a large number of cases, but of extending the observations over a number of separate epidemics. The variation of fatality in different epidemics and seasons is so great that inferences drawn from the mere treatment are highly misleading. Another point of great moment, and one perhaps a little overlooked in the writer's admirable paper, is to be sure, in comparing cases, that the element of *age* is taken into account. The question raised by Sir B. W. Richardson is not a new one. It was raised in one sense by Dr. Todd, and in a very opposite sense by Professor Gairdner, who has been amongst the most powerful, as he was amongst the earliest, advocates of an extremely careful and limited use of alcohol in typhoid fever. Sir B. W. Richardson's paper should be read. The remarks of some who followed in the discussion at the quarterly meeting of the British Medical Temperance Association were not all in such judicial form and taste. One gentleman "never remembered to have had a death from typhoid and thought too much fuss was made about methods of treating it," etc.; but taken as a whole, the debate was characterized by moderation and fairness and will tend to induce practitioners to consider the evils of a careless use of alcohol.

* * *

Paraxanthin as a Cause of Nervous Troubles.—Obscure nervous affections are often difficult to treat and the cause cannot always be found. Dr. B. K. Rachford had some difficulty with a case reported in the *Journal of the American Medical Association* which had epileptiform seizures. On examination he found a substance called paraxanthin, which is a poisonous leucomaine of the uric acid group in excess in the blood and the urine. By isolating this substance and trying its effect on mice he got the following results :

1. Nervousness, extreme reflex excitability—almost a tetanus.

2. Clonic, tetanic stiffening of the muscles, followed by muscular relaxation. (Convulsive movements usually absent.)

3. Dyspnea,orthopnea, asphyxia. The gasping respiration is probably the most characteristic symptom.

4. Heart unaffected.

From this he concluded that paraxanthin occurred in great excess in the urine passed by this patient during the epileptoid attacks already described, and that it is reasonable to believe that paraxanthin-poisoning is a potent factor in the production of these attacks.

* * *

Length of the Lower Extremity in Dislocation of the Hip-joint.—Reidlinger, in the *American Journal of the Medical Sciences*, states that the methods usually employed in determining the amount of lengthening or shortening of the limbs in cases of hip-joint dislocations give erroneous results. He claims that the measurement taken from the anterior superior spine of the ilium will show less alteration than if the measurement be taken from the middle line of the body. It is recommended, therefore, in such cases to take the measurement from the symphysis pubis. The comparative measurements are given in four cases. One of these was a perineal and another an obturator luxation. In these, measurements from the spine indicated shortening, but when taken from the symphysis a lengthening was shown as compared with the sound side.

* * *

External Examinations in Labor.—Leopold and Sporlin (*Archiv f. Gynakologie; Med. News*) make a warm plea for limiting examinations made in the course of ordinary labor to the external parts, and the advantages of such a course.

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BALTIMORE, JUNE 16, 1894.

Nephritis in its Surgical Aspects.

NEPHRITIS as it occurs in the various forms of Bright's disease is usually a very serious trouble and cannot always be guarded against, but cases of so-called surgical kidney and surgical nephritis have been produced by carelessness of the surgeon and of the patient himself. As the normal urine in the healthy bladder is sterile, any contamination arising must have been introduced from without. The healthy urethra contains many organisms, some pathogenic. It follows that the careless introduction of an unclean catheter even in a healthy subject may produce cystitis and hence a nephritis; and this is much more liable to occur in advanced age when the bladder has lost much of its expulsive power.

Dr. E. L. Keyes in commenting on this subject in a paper before the recent Congress of Physicians and Surgeons and which is published in the *American Journal of Medical Sciences*, concludes from preliminary statements that in order to avoid infection of the kidney through the genito-urinary tract it is necessary—

1. To use reasonable care in exploring a healthy bladder or passing any instrument into it.

2. To use greater care if there be traumatism from stone, tumor, stricture, especially if the powers of the individual be weakened by age or disease.

3. To exercise every known precaution in exploring and manipulating, instrumentally, cases of dilated bladder in a fibrotic state, with enlarged ureters and damaged kidneys.

In order to give the practical application to this résumé, Dr. Keyes asks how the kidney shall be guarded. In the answer to this question two points must be kept in view: one, to avoid all unnecessary traumatic violence and the other to maintain asepsis. Keep the rubber catheter to be used in a 1 to 4000 bichloride solution and wash it in hot water before using. Flush the urethra out with this same fluid as the catheter is introduced; draw the urine slowly, watching the pulse; then wash out the bladder with a 1 to 1500 or 2000 nitrate of silver solution and then a six per cent. salt solution may be introduced. The catheter should be used clean in this way every day, but the injections with nitrate of silver may be made every two or three days.

Dr. Keyes also had a bacteriological study made of the various substances used on medicated and non-medicated urine to observe their effects on the organisms of suppuration. The conclusions, which are very elaborate, showed the value of the bichloride. The albumen may or may not be caused by the pus or blood. His summary of conclusions is as follows:

1. Healthy urine is sterile. 2. Purulent urine is always microbic. 3. Microbic infection takes place from within the body by a number of methods in the course of disease; it is often brought about by instrumental manœuvres on the part of the surgeon. 4. A healthy organism and vigorous bladder may cope successfully with microbic invasion, and rid itself spontaneously, or with a little aid, of all damage arising therefrom—showing little or even no inflammatory response. 5. A suitable condition of the patient's soil is essential to the propagation and perpetuation of inflammatory pneumonia upon the urinary tract—after microbic invasion. 6. This condition,

intensified, by traumatism and physical weakness, notably of the degenerative variety, is most intense when there is vesical distention with atony, and when the ureters are dilated and the kidneys involved in the changes incident to tension below—namely, atrophy, and sclerosis above, with or without surface catarrh. 7. Under these circumstances surgical pyelonephritis is most likely to declare itself as a result of microbic infection from below (occasionally from above)—in the course of suppurative disease or after operative interference. 8. Asepsis, antisepsis, and sterilization of urine are ends to be aimed at in genito-urinary surgery—but, like all other greatest goods, not yet attained in perfection. Much, however, can be done by local means in a prophylactic and curative way, little by internal medication, and possibly as much or more than by any other means by flushing the urinary passages with natural mineral waters.

* * *

The History of Medicine.

THE average medical practitioner has very little accurate knowledge of the history of medicine. Anatomical parts, surgical operations and the like are named for men who have distinguished themselves in their respective departments, and yet the history of most of these men is as a sealed book to many physicians who know nothing of the time in which they lived, who they were and what they did. It has often been suggested that each medical school should have a chair of the History of Medicine added to its curriculum. History is replete with the lives of great physicians and surgeons whose names alone are familiar to the average student. The short biographical sketch of Baron Larrey, by Dr. Platt, and which appears in this number of the JOURNAL, is one of the many instances of the physician in history. In the time before, during and after the French revolution, great names occupy prominent places in the history of medicine.

* * *

The Suppression of Tuberculosis.

AT no previous time within the memory of those now living has there been so much written and said about tuberculosis as at present. Realizing that the specific against this disease has yet to be discovered, and that no method of treatment hitherto proposed markedly decreases its mortality, steps are being taken everywhere to prevent the disease at its origin and cut off the infecting principle from those susceptible to it.

With this idea an almost simultaneous movement has been made in many States towards the erection and maintenance of hospitals where tuberculosis, particularly pulmonary consumption, may be treated by rational methods. These consist in good food, most favorable climate and general hygiene, at the same time protecting the subjects from those influences which aggravate the disease and tend to bring the patient to the fatal end. Of course hospitals for chest diseases have been in existence for years, but not until the last few years have so many States and philanthropic bodies taken steps to increase the number and to erect and conduct them on the most recent scientific principles.

* * *

The Ophthalmoscope in Practice.

THE advances in ophthalmology are so great and that specialty has so developed in the past few years that the general practitioner attending a congress of oculists feels as if he were listening to a foreign language. New terms, new expressions, new refinements, show that this wonderful organ of the body is a very fertile field for further observation. In spite of all these difficulties the general practitioner should not be totally ignorant of the eye in all its relations. Every physician should know how to use the ophthalmoscope. This the neurologist is rapidly appreciating, for the close connection between disease of the nerves and of the eye has lately become more apparent. In cases of diabetes the fundus and lens should always be examined. It is well known that Bright's disease can often be made out or strongly suspected long before there is albumen or casts in the urine, and proper treatment in this pre-albuminuric stage is very effective. If the general practitioner would to a limited degree accustom himself to the use of the ophthalmoscope and some of the simpler tests for the eye, he would greatly aid himself, the patient and the oculist to whom he sends his patient.

* * *

DR. JAMES A. STEUART, of the State Board of Health, in his address at the recent meeting of the county board, expressed the conviction that every sanitary officer in the county should be a physician.

MEDICAL ITEMS.

Dr. J. J. Chisolm, of this city, and Miss Elizabeth Steel, of Petersburg, Virginia, were married last Thursday morning.

At the conferring of degrees at the Johns Hopkins University, Reid Hunt, B. A., of Martinsville, Ohio, was made fellow in physiology and Herbert Dodge Pease, M. B., of Toronto, Ontario, fellow in pathology.

The citizens of Rowlesburg, Preston County, West Virginia, say there is an opening for a good physician in their town. Rowlesburg is on the main line of the Baltimore and Ohio Railroad, 25 miles east of Grafton and 75 miles west of Cumberland.

The Providence Hospital, which was founded several weeks ago by eight colored physicians of Baltimore, have taken possession of the building secured for the purpose. The house has been renovated and refurnished. It will start as a dispensary only, but the founders expect to secure additional accommodations for hospital beds in the next few months.

Baltimore has been selected as the next meeting place of the American Medical Association, which convened in San Francisco this year. The following officers have been elected: President, Donald McLean, Michigan; vice-president, T. C. Love, Ohio; treasurer, Dr. Newman, Illinois; secretary, W. B. Atkinson, Pennsylvania; assistant secretary, H. B. Ellis, California; librarian, G. E. Webster, Illinois; editor, J. B. Hamilton, Illinois.

The Garrett Free Sanitarium for Children, at Mount Airy, Md., opened for the summer June 7. It is intended for those unable to send their sick children to the country. Children of twelve years or under, who are sick or in need of surgical treatment, who can be benefited, will be received, provided they have no contagious disease. Application for admission should be made at the Garrett Free Dispensary for Children, 27 N. Carey St. (Franklin Square), any week day, except Wednesday, between 12 and 1, where tickets will be given.

Dr. Hunter Robb, associate in gynecology, Johns Hopkins Hospital, and Miss Isabel A. Hampson, superintendent of nurses and principal of the Training School for Nurses, of that institution, will be united in marriage on July 12, the wedding to take place in London. Miss Hampson will sail to-day from New York, Dr. Robb following on the 27th inst. Miss Hampson received her professional training in Belleview Hospital, New York, afterwards pursuing her studies in Rome and elsewhere. Dr. Robb is a graduate of the University of Pennsylvania and has been connected with the Johns Hopkins Hospital since 1889.

The Board of Medical Examiners of the State of Maryland held the regular semi-annual examination May 3, 4 and 5. Sixty-six graduates in medicine appeared for examination, and of this number licenses were granted to the following fifty-three: James Frederick Adams, Harry Harman Arthur, Caleb Noble Athey, Harry Fessler Baer, A. Duval Atkinson, Geo. Irvin Barwick, Thomas Clinton Baldwin, Charles F. Blake, John Briscoe, Morris A. Birely, Harry Ellis Clemson, Harry Morton Bowen, Martin John Cromwell, Wm. Durbin Brown, Thos. Atkinson Councell, Chas. W. Didenhover, Chas. Henry Dixon, Jr., Geo. W. Dobbin, Vernon H. Dyson, Edith Eareckson, Edwin Lacy Gibson, A. Barrett Householder, Charles J. Dickinson, Walter H. Fenby, John Girdwood, Alfred T. Gundry, G. Herman Hammerbacher, Robert F. Hardesty, John Frederick Hempel, Richard H. Johnson, A. F. Hardlicka, Seth Warner Jones, J. E. Kempter, Edwin Webster Lowman, John T. McCarthy, Chas. Hamilton Medders, John Donaldson Murray, Charles S. Neer, Arthur T. Newcomb, Otto M. Rhinehardt, Robert Charles Reuling, Morris Cooper Robins, John Ruhrah, Andrew Joseph Sauer, C. P. Otto Schaefer, Harry Lee Smith, Wm. Edgar Sperow, O. B. Stone, Stephen S. Stone, Harvey G. Utley, Frank Edgar Wagner, Compton Wilson, E. R. Zemp.

The schools are as follows: University of Maryland, 36 applicants, 3 failed, 1 to 12; College of Physicians and Surgeons, 12 applicants, 4 failed, 1 to 3; Baltimore Medical College, 8 applicants (6 new, 2 old*), 1 failed, 1 to 8, (6); Baltimore University School of Medicine, 3 applicants (2 new, 1 old), 2 failed, 1 to 1½ (1); Howard Medical College, Washington, D. C., 2 applicants, 2 failed, 1 to 1; Woman's Medical College, Baltimore, 1 applicant, no failure; University of Pennsylvania, 1 appli-

*Failed in 1893; re-applied for license at this examination and passed.

cant (examination not completed); Georgetown Medical College, Washington, D. C., 1 applicant, no failure; University of the City of New York, 1 applicant, no failure; College of Physicians and Surgeons, New York, 1 applicant, no failure.

WASHINGTON ITEMS.

A live stock sanitary convention is to be held in Washington, D. C., beginning June 19, and lasting three days. Secretary Morton, of the Department of Agriculture, has been invited to make the opening address.

The District of Columbia, finding its regulations regarding the sale of adulterated milk in the District defective and inadequate, will adopt better measures on the subject very soon. The Commissioners have had a bill prepared to be submitted to Congress. The bill has first been placed in the hands of the Medical Society of the District with the request that the members examine its provisions and submit any recommendations they thought necessary.

A citizen of Washington, D. C., who owns a large dairy farm stocked with registered Jerseys and Holsteins, had the Koch tuberculin test applied to his animals last week by Veterinary Surgeon Buckingham, of the District. Of the ninety cattle inoculated, several were found to be tuberculous. Five of the number were afterwards slaughtered and the presence of tubercle was plainly indicated. A calf, the offspring of one of the affected cows, was also killed and tubercles found in the lungs. Others of the cows have been isolated for future experimentation. The animals killed represented a money valuation of over $1000.

Active measures are being urged for an improved sanitary condition of the Capitol at Washington. The committee appointed for the purpose has reported that the House would not be justified in delaying for a day the making of every provision immediately available to improve the ventilation. The report further says: "Your committee are as sure as of anything that cannot be mathematically demonstrated that the lives of many members have been shortened by the poisonous condition of the air they breathe at the Capitol."

The committee recently appointed by the Medical Society of the District of Columbia to report upon the subject of typhoid fever in the District have submitted a very exhaustive and valuable document. The committee was composed of Drs. G. L. Magruder, W. W. Johnston and Health Officer Hammett. Statistics show that typhoid fever increases in proportion to the saturation of the soil with decomposing organic matter, especially human excreta, and decreases in proportion as a city is well sewered. The report recommends the abandonment of all wells within the city limits; the purification of the sewerage system by replacing defective drains; the extension of the sewerage system; the better draining of the lower sections of the city; the suppression of all nuisances and the enforcement of the law to make sewer connections; the careful inspection of the dairies in the District and the more careful disinfection of the stools from typhoid patients. The report gives New York and Brooklyn the best sewerage systems of the country, and shows that the mortality from typhoid is three times as great in Baltimore and four times as great in Washington as it is in Brooklyn.

OBITUARY.

Dr. Henry G. Leef died suddenly on last Tuesday evening of apoplexy at fifty-three years of age. He was a graduate of the College of Physicians and Surgeons and was engaged in the drug business in Woodberry.

*

Dr. J. C. Brown died suddenly last week in this city from Bright's disease. Dr. Brown was born in Baltimore and was a graduate of the medical school of the University of Maryland, and of the College of Physicians and Surgeons. He practiced medicine more than five years.

*

Dr. John F. Monmonier died last week of old age at his home in this city. He was born in Baltimore in 1813, and was graduated in medicine at the University of Maryland in 1834. Dr. Monmonier was president of the Medical and Chirurgical Society of Maryland from 1875 to 1876, physician to the Maryland penitentiary from 1838 to 1842 and professor of physiology in the Washington University, Baltimore, from 1867 to 1877. He was health commissioner in 1850. Dr. John N. Monmonier, lately professor of anatomy and surgery in the Washington University, is one of the surviving sons.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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NOTES.

EQUAL parts of celerina and aletris cordial in teaspoonful doses will relieve ovarian neuralgia.

*

LISTOL, a chemical compound of thymol and iodine, is said to be a perfect substitute for iodoform.

*

MONOSULPHITE of sodium rapidly eliminates the lead from the system in lead poisoning. About eight grains a day are sufficient.

*

SACCHARINE in doses from fifteen to forty-five grains a day is an excellent intestinal antiseptic in typhoid fever and allied affections.

*

NEPHRITIC colic is successfully treated by pure olive oil in tablespoonful doses every half hour for six hours until the pain is relieved.

*

PURE liquefied carbolic acid repeatedly applied rapidly removes genital warts. The surrounding surface should be well protected with vaseline.

*

BALSAM of Peru in doses of three to eight grains dissolved in alcohol and taken in a little water exercises a very favorable influence in gastro-intestinal affections and dysentery of children.

READING NOTICES.

Peacock's Bromides.—I used Peacock's Bromides with success. In epileptic fits, especially one case of ten years' standing, in which I exhausted all remedies at my command, it has proven a valuable remedy, always positive and constant. I cheerfully recommend it to the medical profession.—HORACE C. GEORGE, A.M., M. D., Altoona, Pa.

*

Europhen.—A three per cent. ointment of Europhen in vaseline had an admirable effect in burns of the first and second degree and in four cases of ulcerating lupus its cicatrisant action was strikingly exhibited. In the treatment of chancroids, of which thirty cases came under observation, Europhen proved a perfect and effective substitute for iodoform.

*

Trional.—Dr. I. N. Love says, in the *Medical Mirror:* "As a sleep-producer I believe that Trional in ten, twenty or thirty grain doses is the best remedy we have at hand. No exaltation, no depression and no bad effects follow its use. I observe, in a recent number of one of my exchanges, a very pronounced tribute to this remedy by Dr. J. B. Mattison, of Brooklyn, N. Y., a high authority. His experience is entirely in harmony with my own."

*

Losophan.—In chronic affections of the skin, Losophan may be utilized with advantage, since it removes the congestion and infiltration and alleviates the subjective symptoms. Excellent results have been reported in chronic cases of eczema, sycosis, acne, rosacea, and ulcers of the leg, while in acute cases its use is contra-indicated. Within the limits of its therapeutic utility, Losophan may therefore be regarded as a most important acquisition to the dermatological materia medica.

*

Elixir Six Hypophosphites.—I have been induced to use your Elixir Six Hypophosphites, in lieu of the various syrups and emulsions of hypophosphites that are in the market, because your Elixir agrees better with the digestive organs and seems to increase the general nutrition more rapidly. I have made it a rule of principle not to give testimonials except I have proven the preparation to be of undoubted value. Yours truly, JOHN A. ROBISON, M. D., Professor of General Medicine, Post-Graduate Medical School, Chicago, etc., etc.

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ORIGINAL ARTICLES.

CLINICAL NOTES ON THE DIAGNOSIS AND TREATMENT OF APOPLEXY.

By George J. Preston, M. D.,
Professor of Physiology and Clinical Professor of Diseases of the Nervous System College of Physicians and Surgeons, Baltimore.

These notes are based on the study of thirty-one cases seen in my service at the City Hospital. With one or two exceptions the cases were seen in the acute stage, the time varying from a few hours to a few days after the onset of the hemorrhage. Of the thirty-one cases, twenty-six were males and five females, an undue disparity since no traumatic cases are included in the list and must be explained on the ground that men are far more apt to be brought to hospital than women.

Twenty-seven were white, four were negroes. In regard to the age of the patients: Three cases occurred under 20 years; none between 20 and 30; four between 30 and 40; five between 40 and 50; ten between 50 and 60; four between 60 and 70; and two over 70. Syphilis and rheumatism were the prevailing diatheses and atheroma, or arterio-sclerosis, was commonly met with. In three cases there was a history of one of the parents having been hemiplegic. The paralysis occurred on the right side in 16 cases, on the left in 13; in two cases there existed an old hemiplegia on the side opposite the recent paralysis. Aphasia was present eight times. General sensibility was abolished or greatly impaired on the paralysed side in seven cases, muscular sense was lost in four cases. No careful observations were made as to temperature sense, which was noted as lost in one case. In ten cases there was loss of consciousness when admitted into the hospital. Slight elevation of temperature was common, but in only two cases was there very marked elevation. Facial paralysis occurred eleven times. General convulsions were seen in three cases; local spasms and twitchings were very frequent. In no case was there marked deviation of the head and eyes. The pupils presented no constant change; sometimes they were contracted, sometimes dilated, more often normal; in only one or two cases was there marked difference between the two. Marked ptosis was seen three times, and occasionally diplopia.

The diagnosis of apoplexy, especially in hospital cases, is by no means always easy. While there are a number of conditions, which more or less closely resemble the coma of intracranial hemorrhage, the most important are alcoholism, uremia and opium poisoning, in the order named. There are no symptoms that may be said to be absolutely differential. High temperature and unequal pupils favor apoplexy, but neither of these symptoms is constant. Conjugate deviation of the head or eyes, facial paralysis, or hemiplegia, stertorous breathing, full, strong pulse, rigidity,

convulsions, with loss of consciousness, are among the most important diagnostic symptoms of apoplexy. In regard to the temperature, there is at first, that is for the first few hours, a fall amounting to one or two degrees, then a rise of one or two degrees; in fatal cases the rise is often four or five degrees or even higher, and this is an important prognostic sign. Convulsions are not apt to occur unless the hemorrhage involves the cortex or corpus striatum. Comparing these general symptoms with alcoholism we find that as a rule the coma of alcoholism is much less profound than in apoplexy; the delirium of alcoholism is apt to be much more violent, evidences of vomiting are frequently present, respiration is not as labored, and the pulse is not so full and is more rapid. Convulsions are practically never seen in alcoholism. In uremic conditions the coma is less profound than in either of the preceding states, the temperature is apt to be depressed, convulsions are very common, and albumen is present in the urine. Stertorous breathing is not present, or at least not marked as in apoplexy, and there is usually œdema present. In opium poisoning the coma is not as marked as in apoplexy, it generally being possible to arouse the patient, the pulse and respiration may be characteristically slowed, and convulsions rarely occur.

The various symptoms detailed above are by no means all the symptoms met with in the respective conditions, but are merely the more prominent ones. In regard to the rise of temperature in apoplexy, we see that it does not come on in the first stage, and is by no means a certain accompaniment of the later stages. Its value is very considerable as a positive, but very slight as a negative, symptom. The nature of the coma and the character of the delirium differ in the four conditions, but differ mainly in degree. The state of the pupils is not constant in any one of the conditions in question. It is a matter of remark how often the pupils show no very marked change in opium poisoning; and the same may be said of pulse and respiration. Convulsions are not seen in alcoholism, but are not unfrequent in apoplexy, are very common in uremia, and may occur in opium poisoning; in a case of the latter affection seen not long ago there were marked convulsive seizures. The smell of alcohol on the breath is not worth much as a diagnostic sign; in the first place it is too much of a normal symptom, unfortunately, to be placed in evidence, and in the second place the alcoholic subject is especially liable both to uremia and apoplexy. The same may be said in regard to the appearance of albumen in the urine; a subject with arterio-sclerosis is apt to have albuminuria, and very prone to rupture of the diseased arteries and apoplexy. A safe rule in doubtful cases is to use the soft stomach tube, which can do no harm, and if there be any opium still unabsorbed it is gotten rid of, and if there be a large amount of alcohol in the stomach the removal of it is very desirable. It must be borne in mind that whiskey is the universal medicine and is most indiscriminately administered, so that the smell of it on the breath may lead to very false conclusions as to the habits of the patient. The symptom that is worth most in distinguishing apoplexy from the other conditions named is paralysis. Where there is marked facial paralysis, the nature of the case is at once apparent. In the acute stage, however, during the period of coma, it is generally very difficult, and often impossible to be at all sure of the presence of paralysis, unless there is at the same time involvement of the facial nerve. The limbs may be rigid or entirely limp, and prolonged watching may fail to detect any difference in the movements of the two sides. A procedure, which is not generally laid down in the books, but which I have found very valuable, is to test the limbs carefully with a pin. In alcoholism, unless it be very profound, in uremic conditions and in opium poisoning, it is nearly always possible to elicit the same response from the two sides. In intracranial hemorrhage with hemiplegia, one can often demonstrate that paralysis exists upon one side. Sometimes the para-

lysed limb will respond very slightly, sometimes not at all. Again it often happens that, as in the frog from which the cerebral hemispheres have been removed and one side forcibly restrained, the sound limb will reflexly attempt to remove the irritation from the other side. It is evident that there are no symptoms that are constant and differential, and it follows that each case must be studied with the utmost care and the diagnosis arrived at from the *tout ensemble*. A reliable history, if it can be obtained, will of course often clear the case up. The sudden onset, with perhaps a traumatic history, points to apoplexy, while in the other conditions coma comes on gradually, and in the case of uremia usually preceded by rather than in advance of the convulsive seizures.

It happens now and then that hysteria is mistaken for apoplexy, and *vice versa*, though as a rule there is no difficulty in making the diagnosis between the two conditions. I saw once in consultation a case that had been diagnosed hysterical lethargy; the patient was an hysterical woman who had for some years been the subject of almost all forms of this protean affection, and among other symptoms had frequently had attacks of hysterical lethargy. The pulse and respiration were suggestive rather of intracranial hemorrhage than of hysteria, and the thermometer showed a temperature of 103°; a diagnosis of apoplexy was made, and an unfavorable prognosis given, based on the fact that the condition had lasted for twenty-four hours and the temperature was still high; death occurred in twelve hours. A negro woman was recently brought into the City Hospital by the police with an indistinct history of convulsions and unconsciousness; she was anesthetic, the limbs were rigid and every effort was made to arouse her to consciousness without avail. At last as an experiment I closed the eyes, which were partly open, and made the suggestion of sleep. In a few minutes she was hypnotised, and the suggestion was made that she would be all right when she waked up. This suggestion was repeated a number of times and she was then wakened, and at once jumped up with the somewhat characteristic expression, "Where am I at?"

The limits of this paper do not permit any discussion of the difference between hemorrhage and embolism and thrombosis, a difference, by the way, that is of no great interest to the general practitioner. For the same reason nothing can be said concerning the localization of the hemorrhage; while a number of the cases here reported went to autopsy, space does not allow any detailed account of them, and there were not enough cases from which to draw any general conclusions.

In regard to the treatment of apoplexy, more might be done in the prodromal stage if this condition were more carefully studied, and oftener recognised. There are no constant or certain prodromata, but in a considerable proportion of the cases here related, the history obtained afterwards from the patients showed the existence of headache, vertigo or a sense of fullness in the head, numbness of one side, etc. These symptoms in some instances existed for a week before the apoplectic attack. It is very important to heed these warnings, especially in cases where there is atheroma of the vessels, or where there is high arterial tension without atheroma. Rest, vascular sedatives, nitroglycerine, large enemata, will often modify the force of the circulation, and thus tend to avert the rupture of the artery. Some years ago I was called to see an elderly woman, stout, with flushed face, headache, and unusually high arterial tension. While waiting for the family physician, she was kept absolutely quiet, with ice to her head. While we were consulting in the next room, the patient, against orders, got up to use the commode, the arteries could stand no further strain, rupture occurred, and she died in half an hour with all the symptoms of intracranial hemorrhage. Venesection would probably have averted this disaster. It rarely happens that the physician sees cases early enough to make use of blood-letting. After the rupture of the artery has taken place, it

is doubtful whether venesection does any good. The most important part of the treatment of apoplexy is rest. There is no way by which the bleeding can be stopped, and it is probable that in the great majority of cases the increased intracranial pressure tends to control the hemorrhage. The ruptured artery, or miliary aneurism, is small as a rule, and it is generally soon occluded by clot. If the amount of hemorrhage is moderate and not in a vital part of the brain, recovery, more or less complete, will take place if the clot remain in its first position.

Very often it happens that the original location of the clot was not specially dangerous, but from gravity, or as the result of exertion, the clot has forced its way through the soft brain tissue and done irreparable injury to more important structures. This can often be seen post-mortem and the track of the clot made out. From this it follows that the greatest care should be exercised to prevent any more moving of the patient than is absolutely necessary. If it be possible the patient should be laid down on a sofa or mattress in the room where the attack occurs, and no attempt at movement made for 12 or 24 hours. It is better to slightly elevate the head by pillows, since this probably tends to modify the force of the heart's action in the cerebral vessels, and at the same time allows respiration to be carried on rather better than when the patient is perfectly flat. Opening the skull has been resorted to, but it is doubtful whether this is advisable except in the case of meningeal or cortical hemorrhage. The ice cap to the head is of some use in allaying restlessness, and is extremely good treatment for the relatives and friends. In regard to drugs in this early stage, there are practically no therapeutic indications that can be sucessfully met. The use of ergot and that class of remedies is of more than doubtful propriety. Aconite may sometimes be used to advantage in controlling a too forcible heart's action. As soon as the patient can swallow it is my custom to administer a mixture of bromide and iodide of potash, 30 to 40 grains of the former and 10 grains of the latter, and this is kept up for several days, then the bromide is omitted and the iodide used alone in increasing doses. I am confident that this treatment has been of service in my hands. In regard to the custom of administering croton oil or some drastic purge during the early stage, although sanctioned by almost immemorial usage, it is not only useless, but exposes the patient to the risk of making dangerous exertions, besides putting him in a filthy condition. The same objections in part apply to blistering, and the use of mustard. It is important to attend to the bladder, and draw off the urine at regular intervals. The throat should be kept as free from mucus as possible, and the surroundings of the patient rendered comfortable. These points have perhaps been dwelt upon with unnecessary minuteness, but one so often sees these cases handled in a mischievous manner. The physician, realizing the futility of any active treatment, is too apt to yield to any suggestion made by the family, and the object of this paper is to insist upon a simple and rational treatment of this condition.

HYPERPYREXIA AS A COMPLICATION OF RHEUMATIC FEVER.—Dr. Nathan Raw, in writing on the subject of Acute Rheumatism (*The Lancet*), says:

Hyperpyrexia as a complication of rheumatic fever is fortunately a very rare occurrence and unless treated promptly and vigorously is always fatal. A temperature of 107°F. occurring rapidly and preceded or accompanied by delirium or partial unconsciousness, cessation of pain and perspiration, vomiting with cyanosis, rapid, irregular pulse, and sighing respiration is generally regarded as the index of approaching death. It is now universally acknowledged that the excessively high temperature in cases of rheumatic fever, apart from the effects of micro-organisms in the blood, is the real cause of the supervention of dangerous cerebral symptoms, and therefore the attention of the physician must first of all be directed towards reducing the temperature, if possible, before the heart and the tissues generally have been too much damaged by the excessive heat.

THE EFFECT OF BICYCLE RIDING ON THE FEMALE PELVIC ORGANS.

Read Before the Gynecological and Obstetrical Society of Baltimore.

By James M. Craighill, M. D.,

Baltimore.

The very extensive use of the bicycle by both sexes and the increasing number of female riders naturally causes the medical advisers to inquire into this popular sport and consider as to the advisability of its indulgence, or ask if, like the sewing machine, it should be condemned?

Much has been written in the daily press for and against this form of sport, also to some extent in the various medical journals of this country and Europe, but I have been unable to find a word relative to the female cyclist after reference to all the medical writings at my disposal.

During the past six or seven years observations among my own patients and acquiring as much information as I could collect about other female cyclists, lead me to think that the exercise is very beneficial to them, especially with the improved machines of the present day, and should be encouraged in moderation.

It is needless to say that this form of athletic sport, like any other, can be very much abused; such as overtaxing the muscles by trying to ride hills too steep, riding too far and too fast, not sitting properly on the wheel and many other ways that might be mentioned. The fad among the male riders at the present time is to have the handle-bars of the machine so low that many of them sit with their bodies at an angle of 45 degrees. While it is obvious this is a very injurious custom in many ways for the male, it would be much worse for the female and as far as I know none of the latter sex have been so foolish as to adopt that position.

Nothing will more rapidly improve that class of anemic women which every medical man meets in his daily rounds suffering from backache, ovarian pain, leucorrhea, etc., caused by a general relaxed condition of the pelvic organs, in unison with her general run down condition, than proper exercise, and it is the custom among physicians to advise women suffering in this way to exercise in the open air, this being regarded as much more likely to do good than the various tonics that are prescribed in such cases. The exercise usually consists of a walk of possibly a mile for the first day or two but, becoming tiresome, is not tried long enough to do good; if our patient is put on a bicycle she soon becomes very enthusiastic, and indulges whenever an opportunity presents itself, and if properly instructed, wears loose clothing, with no corsets, sits erect on her wheel, exercising every organ and muscle in her body, and as her course naturally leads her out of the city, she gets the benefit of the pure country air and her exertions make her breathe in much larger quantities of air, thus purifying her blood and adding health and strength directly to that part of her body to which our attention is directed in this paper. This is a very different picture from her sister bending over the sewing machine, usually in a close room, with her corsets drawn tightly, crowding all of the abdominal contents down on her pelvic organs, with the subsequent congestion and the many female troubles with which we are all familiar.

Horse-back riding is probably the next best exercise to the bicycle, but from a financial as well as gymnastic point of view, also general convenience, the cycle is the better.

Of course there are many conditions of the female organs that would prohibit this exercise which are unnecessary to mention, but any condition that would admit of the equestrian exercise would

be much benefited, and most troubles in which any kind of self-exertion would be of benefit can for the reasons given be safely prescribed.

It is even customary with some to ride during the menstrual period and apparently with no harm resulting, although the writer of this paper would include riding at that time among the abuses.

A few cases of pregnant women riding have come under my care, and while the number of cases are too small to arrive at any definite conclusions, still it is the writer's opinion that if the woman has been accustomed to the exercise before she was in that condition, it will not injure her to continue it with proper care during the first six months of her gestation. A novice would run great risk of doing herself much injury in that condition from the exertion, numerous falls, etc., due to inexperience.

One of my patients, a well-developed young woman, had been riding her wheel several years before her marriage and continued to do so after she had become pregnant and until she was about six months advanced, notwithstanding she had been cautioned by me to desist. Her wheel (at that time the best to be had) was of the solid tire pattern, heavy and hard to propel, and she used no care in straining when riding up hills or over rough roads. After a difficult labor, position right occipito-posterior, I delivered her with forceps with a resulting badly torn perineum and bowel which was repaired by a secondary operation. After recovery she again took to the wheel and is one of the best female cyclists in this city to-day and has never had the least uterine trouble since that date, now five years ago, although she has had several abortions which the writer has reason to think were brought on intentionally on her part.

Another patient had been riding a number of years before marriage and continued the exercise regularly up to two months before the birth of her child. She rode a very easy running wheel with pneumatic tire and during the last few months was on a tandem wheel with her husband.

My former experience with a pregnant bicyclist caused many misgivings on my part about her riding at all after she became in that condition. She continued to do so after being warned not to pull up hills or exert herself very much at any time. The instructions were obeyed and her confinement was in every respect normal, with very little pain, and one of the easiest labors I ever attended. There has been no subsequent uterine trouble.

The history of the next case was gotten from the husband, as she has never been treated by me.

Mrs. L., aged 27, mother of two children, had suffered much from uterine trouble, probably a partial procidentia, with great pain during menstrual period. Before commencing the use of the wheel she had been treated by several physicians for her trouble and had found some relief from a pessary.

She had ridden very little before the birth of her first child and had an extremely difficult labor. When pregnant with her second child, she rode up to the fifth month and at her second delivery had, just the reverse of her first, an exceedingly easy time of it. During the past seven years she has exercised regularly on her wheel and has had no uterine trouble whatever. While the writer admits that this woman may have been cured by becoming a mother, still I am inclined to attribute much of her improved health to the outdoor exercise on her wheel.

I could mention other cases where the patients suffered much from dysmenorrhea until they adopted the wheel for exercise and then suffered very much less during their periods or were free from pain entirely.

While the few cases cited in this brief paper prove very little, still I thought in writing it I might call the attention of the members of this Society to the many good effects to be derived from this very attractive sport and health-giving exercise.

THE Pope has decided that cremation, while heretical in principle, may be allowed under special conditions.

A NEW METHOD FOR REDUCTION OF FRACTURES OF THE LOWER END OF THE RADIUS.

Read Before the Philadelphia County Medical Society.

By Thomas S. K. Morton, M. D.,

Professor of Surgery in the Philadelphia Polyclinic; Out-patient Surgeon to the Pennsylvania Hospital; Assistant Surgeon, Orthopedic Hospital.

The particular method of reducing fractures of the lower end of the radius, to be described, has proved so satisfactory during the past few years in my services at the Pennsylvania and the Polyclinic Hospitals and elsewhere, and in the hands of others to whom I have from time to time demonstrated it, that I now feel justified in giving to it wider publicity. The method is as follows:

The surgeon stands in front of the patient and interlaces his fingers beneath the supinated wrist and palm of the injured member, so that his two index-fingers lie parallel crosswise beneath the lower end of the upper fragment of the radius. The palms of the surgeon's hands are then closed in upon the thenar and hypothenar portions of the patient's hand respectively, while the surgeon's thumbs rest parallel lengthwise upon the upwardly displaced lower fragment of the radius. The parts are thus firmly grasped by the surgeon while the following movements are made: The patient's wrist is excessively extended by carrying his hand upward. When hyper-extension has thus been secured the surgeon makes powerful traction upon the wrist in the line of hyper-extension. While this traction is maintained the hand is suddenly carried into full flexion, and at the same time powerful downward pressure upon the upwardly displaced lower fragment of the radius is made by the surgeon's thumbs opposed by the interlaced index-fingers beneath the lower end of the upper fragment.

The excessive extension of the first portion of the movement has always, so far in my experience, loosened or disentangled the displaced lower fragment, while the subsequent traction, flexion, and direct thumb-pressure have not yet failed to accurately force the lower fragment into its proper position. Separated epiphysis of the lower end of the radius is likewise easily reducible by this manipulation. For comminuted or complicated or very oblique fractures extension and moulding alone are called for in most instances.

Anesthesia is unnecessary for making a single effort at reduction by the proposed method. The patient does not anticipate what is coming, the two movements are made with lightning-like rapidity in a small fraction of a second, and, in nearly every case, perfect reduction has been accomplished before the patient realizes that he has been hurt. Should the manipulation fail to secure perfect reduction at the first attempt, I would not repeat the manœuvre until anesthesia had been induced, for the pain of repeating it would be intolerable. Failing in one effort, then, I would etherize and try again, first, this, and afterward, if necessary, any other method that seemed advisable to secure perfect reduction. But thus far in cases that have been seen within a week of the accident I have never had to anesthetize since evolving the method mentioned; all have been reduced at the first attempt.

In cases older than one week, with displacement persisting, I anesthetized before making any effort at reduction. The new method may then first be resorted to, and will often be found the best means of performing both refracture and reduction.

For making a diagnosis I have also found a modification of this method most useful. If the surgeon will take the hand and wrist in which fracture is suspected into his hands, as above de-

scribed, and, while the thumbs press firmly upon the lower end of the radius or first row of the carpus, make a series of gentle, quick, short flexions and extensions of the joint—rocking it through an arc of perhaps 25 or 30 degrees above and below the forearm as a horizontal plane—he will be astonished at the ease with which crepitus of the bone of the joint and of any small or large bony or cartilaginous fragment will be elicited. And, best of all, the diagnosis of these obscure fractures about the wrist can thus, after some practice, be brought out without giving unbearable pain to the patient. Indeed, I have often in this way, by the most gentle and practically painless manipulation, been able to clear up the nature of intricate injuries about the wrist.

By practicing the method upon a normal wrist a sufficient degree of expertness can readily be acquired ; by it joint crepitation can be brought out in any wrist. It is well, however, not to practice too much or too often upon the same extremity, as excessive stirring up of the joint contents might originate a synovitis.

In conclusion, the writer desires to say that he will be gratified to have reports of the experience of others who may be tempted to employ the method here put forth.

THE TREATMENT OF STRANGULATED HERNIA.

Read Before the Philadelphia Academy of Surgery, May 7, 1894.

By John Ashhurst, Jr., M. D.,

Philadelphia, Pa.

Looking over my records I find that I have operated on nineteen cases of strangulated hernia, and in addition have operated on two cases of irreducible omental hernia, not strangulated. I have, of course, seen a large number of cases where I have succeeded in reducing the hernia by taxis. I have not kept a list of these, but the number is at least as large, if not larger, than the number of those operated on. While the number of my cases may seem small in comparison with that reported by others, this very fact confirms the view which I have always entertained—that strangulated hernia is a rare affection in Philadelphia, and rarer in this country than in the countries of the old world, England and Ireland particularly. Although the cases are few in number, yet following the old maxim —"*Observationes non numerandæ sed perpendendæ sunt* "—it has seemed to me that it might be worth while to bring them before the Academy, so as to introduce the subject for discussion.

Of the nineteen operations for strangulated hernia, fourteen were for inguinal hernia, confirming what everyone knows—that inguinal is the most common form of strangulated hernia, and the one that most frequently calls for operation.

One of these cases was in a child, operated on at one of my clinics and at once removed by the parents, and the further history of that case I do not know. Of the other thirteen patients, ten recovered and three died. The deaths occurred in cases where a fatal termination might have been expected, and were not due to the operation. In one case the hernia had been strangulated for five days and the patient was a pronounced diabetic. He died of gangrene after the operation, dependent upon the diathetic condition and upon the prolonged strangulation. The second death occurred in a woman of seventy-eight years. The strangulation was very tight, and the bowel was gangrenous at the time of operation. Rupture occurred at the sulcus corresponding to the line of constriction, and death took place from exhaustion in the following twenty-four hours. The third death occurred in a man of intemperate habits, who had a hernia strangulated for thirty hours and who had been subjected to forcible taxis before admission

to the hospital. So forcible had been the taxis that it had resulted in rupture of the bowel in two places. At the operation the scrotum was found enormously swollen and black from effused blood. Twelve inches of the bowel were gangrenous, and the gut presented two openings. I removed the bowel and performed a circular enterorrhaphy, but the patient died thirty-two hours afterward from cardiac failure, without evidences of peritonitis. It is evident that in none of these cases was the result in any way due to the operation.

Four times have I operated for strangulated femoral hernia, with three recoveries and one death. In the fatal case the patient died in a collapsed condition thirty-six hours after the operation. I have no particulars of the case, but there was no evidence of peritonitis.

I have had one case of strangulated umbilical hernia which terminated fatally. The patient was eighty years of age, and the strangulation had existed for a number of hours. The patient died of peritonitis, which, as we all know, is particularly apt to occur as a complication after umbilical hernia, incisions into the upper portion of the abdomen being more apt to be followed by peritonitis than incisions in the lower portion.

The youngest patient on whom I have operated was a child two years of age, with inguinal hernia. This case ended in recovery. The oldest patient was the woman eighty years old, with umbilical hernia, just referred to.

Among cases of special interest I would mention one of the inguino-crural variety, where the hernia after coming down through the inguinal canal does not pass into the scrotum, but turns up in the line of Poupart's ligament and passes outward along the groin. It is usually complicated, as it was in this case, with an undescended testicle. In this case the hernia had been down six days when I operated. I was able by taxis to reduce a portion of the tumor, but finding that there still remained a hard mass which could not be reduced, I thought it right to open the sac and determine the exact condition. I found that the hard lump was the testicle in a gangrenous state, either from a twist in the cord or, as seemed more probable, from the taxis which had been practiced rather violently before the patient's admission to the hospital. I excised the testicle and the patient recovered.

I have operated in two cases of irreducible omental hernia. In these cases a tumor had been present in the tunica vaginalis for a long time, and while there were no symptoms of strangulation, the weight and bulk of the tumor gave great annoyance, and the patients were exposed to the risk of a portion of the gut coming down at any time. I, therefore, felt justified in operating in these cases, cutting away most of the omentum after securing its neck between two ligatures.

The points of special interest in the treatment of strangulated hernia which I would suggest for discussion are, as regards the resort to taxis, its limitations and the aids to its performance, and then as regards operative treatment, the particular mode of performing the operation, more especially as regards the direction of the deep incision, in regard to which some difference of opinion prevails, and as to the advantages and disadvantages of Gay's method as modified by Fergusson, and as to the advantages or disadvantages of Petit's plan of operating without opening the sac.

The limitations of taxis. I feel obliged to say that while I have reduced a good many strangulated hernias by taxis, while I think that it should be the surgeon's first thought, and while if practiced with care and skill it is a safe method, and one which will usually succeed when resorted to in time, yet I must express my belief that in the hands of an inexperienced practitioner, who sees but few cases of hernia, taxis is an unsafe procedure. Under such circumstances, I think that the patient would sometimes be safer with the operation of herniotomy than with taxis, for herniotomy is not a very difficult operation and not very dangerous if performed with caution, whereas taxis, while seeming to be very simple, yet if employed

with great persistence and force may lead to the most serious consequences. My own cases of herniotomy which resulted fatally had been mostly subjected to prolonged taxis. Taxis, therefore, I think, has its limitations, and should be resorted to with great gentleness and with great caution, except in the hands of those surgeons who are sufficiently familiar with the anatomy and treatment of strangulated hernia to feel that they may use the method more freely and more systematically. It is, of course, known to the Fellows of the Academy that its founder, the late Professor S. D. Gross, maintained that very few cases of hernia required operation. He prided himself that he was able to effect reduction by taxis where others had failed; and such was undoubtly the case. In the hands of a man like Professor Gross, taxis was a safe procedure, but in the hands of the ordinary practitioner I believe that the line of safety for the patient will often be found in herniotomy rather than in a prolongation of taxis.

It is scarcely necessary to say that when taxis is employed it should be done with gentleness and with system. The ordinary method of pushing at the hernia is very uncertain, and is not only apt to do harm, but is almost sure not to do good. The rule that the last portion of bowel which has come down should be first returned is very valuable and should always be borne in mind. Then I find what I am in the habit of speaking of to students as a kind of conjoined manipulation, a very useful mode of applying taxis, and I think the safest. The neck of the sac is grasped by the thumb and fingers of one hand, while the other hand, spread out, exercises a combination of pushing and sqeezing; and then by a kind of alternating movement, slightly relaxing one hand while with the other the pressure is increased, if the hernia is reducible at all, it will go up. If no gurgling is heard in a few minutes it is not likely that taxis will succeed.

As regards the *aids to taxis*, the older surgeons resorted to many modes of assisting taxis, but in modern times surgeons have pretty much come down to two or three. Even the warm bath, which was much resorted to formerly, I think is seldom employed at present. At the Pennsylvania Hospital, our practice is to put the patient in bed, apply ice over the hernia, and give a moderate quantity of opium. When the resident physician is not able to reduce the hernia by gentle taxis, this course is followed until the surgeon has been summoned. It often happens that when the surgeon arrives he finds that the hernia has been reduced spontaneously or disappears under the slightest touch.

If this fails, our rule is to administer ether and again employ taxis, and in this way the hernia can usually be reduced. Before administering ether we have an understanding with the patient that if taxis does not succeed then the operation is to be resorted to.

Another manipulation which is of great importance is to draw down the hernia a little before beginning the upward pushing movement, the object being to disengage the portion of bowel which is nipped by the source of constriction. The plan known as Seutin's I have never seen of avail, and I can hardly conceive of a case where it would be required, in which it could be used successfully. This plan consists in endeavoring to introduce the finger or thumb-nail into the constricting ring, which is then stretched; this could be practiced only in very thin persons, and where it could be done I think it probable that taxis would succeed without it.

With regard to *herniotomy*, the first question that will have to be decided is the extent of the external incision. Some operators make a large incision, extending over the entire length of the hernial tumor. Others endeavor to effect the operation through a very small incision, as in Gay's method. My own plan is to make the external incision three or four inches in length, and over the neck of the sac. As regards the particular method of making the incision, whether by pinching up the tissues, transfixing, and cutting outward, or by cutting down from without, I really think that there is no choice. My own practice is to employ the latter

plan. Having gone through the skin and fascia, the surgeon, of course, takes up the tissues cautiously, dividing them on the director. The next question is whether or not the sac shall be opened. I agree with the English rule, that where it is justifiable to resort to taxis it is proper to endeavor to reduce the hernia without opening the sac. I have often tried to do this, but have been compelled to open the sac, as the constriction has been in its neck. In making the deep incision the tip of the left forefinger should be pressed against the source of constriction and the hernia-knife passed flatwise; this is then turned in the proper direction and the deep incision made with a gentle sawing motion, assisted by pressure of the finger below. I am satisfied that the rule of the English surgeons, to make the incision directly upward in inguinal hernia, is the correct one. While in a certain number of cases the surgeon can say this is a direct, or this is an oblique hernia, yet in other cases the relation of the parts is so confused that he cannot be absolutely certain which form of hernia he is dealing with. In the one case the internal epigastric artery will be on the inside and in the other on the outside. The safe rule, therefore, is to make the incision directly upward and in the line of the long axis of the body. In femoral hernia the deep incision should be made upward and inward. It is only in this direction that we are safe from doing injury and certain to reach the source of constriction, this being where the falciform process and Gimbernat's ligament join. The only danger from hemorrhage when this plan is followed is from an abnormal distribution of the obturator artery. To avoid wounding this, a good plan is to adopt Mr. Erichsen's suggestion to blunt the edge of the hernia-knife by rubbing it on the handle of another knife, or, as suggested by Dr. Wyeth, to keep the point of the knife firmly pressed against the pubis.

In umbilical hernia the safe line of incision is in the median line, and directly downward. The operation is apt to be followed by peritonitis under any circumstances; but I think that there is less danger if the incision is made in this way, on the general principle that wounds in the lower portion of the peritoneum are less likely to be followed by peritonitis than those above. In the case on which I operated the hernia was of long standing, but the strangulation was recent, from the protrusion of an additional portion of bowel. There I followed the judicious rule of not attempting to reduce the whole hernia, which would have required an extensive dissection, but simply relieved the strangulation and returned the part recently protruded.

With regard to the method of dealing with the contents of the hernia, I think that all surgeons agree that if the bowel is healthy it should be returned, but that if gangrenous it should be left in the wound and a false anus formed. If a distinct sulcus is found I think that it is a good rule not to reduce the bowel, so that if it should give way the extravasation may be outside of the peritoneal cavity. As regards the omentum, I think that it is a safe rule to cut it away pretty freely. If it is perfectly healthy it is proper to return it, but if there is doubt it is safer to remove it.

With regard to after-treatment, I am sure that the safest mode is not to make any attempt to get the bowels opened. Some surgeons are in the habit of giving a dose of oil immediately after the operation, and some even before the operation; but it seems to me to be injudicious. I put the patient on the use of opium and belladonna for a few days, gradually diminishing the dose, and usually the bowels move spontaneously in five or six days.

The number of cases which I have brought before you is limited, but they represent a sufficient variety to perhaps be available for the discussion of some of the points suggested.

Freckles and the Red Parasol. —The fashionable "fad" in Chicago of the red parasol, says an exchange, is now defended on the ground that it is an efficient freckle preventer—the actinic rays of the sun, which it is claimed are the cause of the pigmentation, being intercepted in passing through a red medium.

SOCIETY REPORTS.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 20, 1894.

THE 295th regular meeting was called to order by the President, Dr. J. Edwin Michael.

Dr. W. E. Moseley read a paper on THE IMPORTANCE OF A MICROSCOPICAL EXAMINATION IN THE DIFFERENTIAL DIAGNOSIS OF DISEASES OF THE UTERUS, treating the subject from a clinical standpoint.

Dr. W. T. Howard, Jr., followed with a paper on the same subject from a pathological point of view.

Dr. H. Harlan read a paper on CASES OF FOREIGN BODIES IN THE EYE, ASSOCIATED WITH SYMPATHETIC OPHTHALMIA.

The first was that of a young man, aged 37, who had received a blow in the eye from a piece of the head of a nail fifteen years previously. He consulted me because the good eye had recently been growing misty. Ophthalmoscopic examination showed iridoplegia and slight neuritis with the dimness of vision, and regarding the trouble as of sympathetic orgin, advised enucleation of the lost eye. The bit of steel was found just posterior to the ciliary bodies.

Case 2 was a farmer, aged 38, who came with the right eye red and inflamed, without light perception and painful to the touch. History was, that seven years previous, while passing through a woods, he had been struck in the eye by a branch of a sweet gum tree. Eye has been more or less painful ever since, at times very painful. The sound eye had never given any trouble. After enucleation the eyeball was opened and just behind the iris was found an entire small terminal bud, conical in shape and covered by the hard shell that is found over the buds of sweet gum in late winter.

Here we have two cases where a foreign substance remained in an eye many years—one fifteen years and the other seven. One a particle of steel which possibly entered in an aseptic condition. The other a fresh growing vegetable fibre. One remaining quiescent for fifteen years and then setting up sympathetic trouble in the good eye; the other probably carrying many organisms and causing nearly constant irritation for seven years and causing no trouble whatever in the sound eye.

Dr. Harlan then considered at some length the history of sympathetic ophthalmia, its causes and the various theories as to how it is brought about. He was rather inclined to take issue with Deutschmann and to support the ciliary nerve theory, concluding as follows:

"We must admit that notwithstanding a great deal of well directed experimental work, little has been accomplished towards the solution of the problem of sympathetic ophthalmia. The fact that its infectious origin has not yet been clearly proven is to my mind one of the strongest arguments against its being of that nature. If infectious, micro-organisms ought to be present always and frequently found in eyes taken out for causing sympathetic trouble in the fellow eye. Again, if infectious, by whatever means the infection spreads, whether by way of nerves, blood vessels or lymph channels, there is no satisfactory explanation of the disease being so strictly a local one."

Dr. Hiram Woods said that the nature of sympathetic ophthalmia seemed as mysterious as ever. He did not think that Deutschmann's explanation had been completely overthrown. His researches, as well as those of Alt and Gifford, had proved that infection of one can involve the other eye; that the path lies most probably along the lymph channels of the optic nerve, the orbital vessels and sub-dural space. Negative cannot always set aside positive testimony. In this instance it has proved that infection of one does not necessarily involve the other eye; possibly does so only rarely. The well-known infrequency of sympathetic ophthalmia after panophthalmitis is a bit of clinical evidence against the liability of an eye to become inflamed when its fellow is suffering from an infection. Dr. R. L. Randolph was quoted as authority for the statement that or-

ganisms are rarely found in the eye enucleated after sympathetic disease has started in the other. All this proves that there must be some other explanation than infection; but does not disprove the possibility of the latter against well authenticated positive results.

Dr. Woods narrated two cases of sympathetic ophthalmia following injuries which did not destroy sight. In one patient both eyes were ultimately destroyed by the plastic irido-cyclitis, light perception alone remaining. In the other the injured eye eventually retained better vision than the other.

H. O. Reik, M. D., Secretary.

CORRESPONDENCE.

THE HEALTH OF LUTHERVILLE.

Editor Maryland Medical Journal.

Dear Sir:—Every season many of the city physicians are consulted by their patients with regard to going to the country, and for years several hundred visitors have found their way to Lutherville. In July, 1891, two cases of typhoid fever occurred at one of the large boarding houses. Both patients were in bad health on their arrival and no satisfactory explanation of any local cause was found. Several other cases of typhoid fever occurred afterwards in the city among persons who had spent part of the summer in this same boarding house.

During the nineteen years I have practiced in Lutherville I feel confident that every case originated outside the village with perhaps three exceptions and these admit of many doubts. One was a child who had not been away from home. The well on the farm had dried up and water was hauled in a barrel from an exposed surface spring in the woods half a mile from the house. Last year a lady died in the village from typhoid fever undoubtedly contracted on her trip to the World's Fair, for the symptoms developed within two weeks after her return.

I think, if the public was more fully informed as to the present theory of how people take the disease and how the germs lie in the system from two to three weeks without marked symptoms, they would realize how easily they can imbibe the germs in a glass of water or in food on their daily rounds, and they would not be quite so ready to blame their boarding house in the country.

Contrary to sensational and unfair reports, I can truly say that Lutherville is a "distressingly healthy" place for a doctor! We have been wonderfully exempt from contagious diseases. I know of no deaths in the village from diphtheria or croup and only one from scarlet fever in nineteen years, nor have I had a severe case of chills and fever in that time. The village stands at least four hundred feet above sea-level. There are no stagnant ponds around, and, by the way, I would like to call your attention to the fact that we are located within the circle marked as the driest portion of Maryland. See map No. 4, prepared by members of the Johns Hopkins University for the Board of World's Fair Managers of Maryland.

In many respects our village is improving and we have eight artesian wells. I have no hesitation in saying to my professional brethren of the city: Send all your patients out to Lutherville unless you are afraid they will return to the city so strong as not to need your services in the future.

Respectfully yours,
J. Chalmers Peebles, M. D.,
Lutherville, Md.

Cocaine-Poisoning.—Krogius, in the *Therapeutic Gazette*, cites cases collected by Réclus, all due to colossal doses, and holds that, instead of injecting the drug just beneath the skin or in the substance of this, it should be driven deep down as near as possible to nerve-trunks. The injection should be made as the needle is being withdrawn. From 15 to 20 drops of a two per cent. solution are employed. After about ten minutes complete anesthesia over a comparatively large area is produced. Thus, in the case of the fingers, for instance, by driving the injection in at the root, near the position of the supplying nerve-twigs, the entire finger to its deepest part becomes completely anesthetized.

MEDICAL PROGRESS.

LIGATION OF THE BASE OF THE BROAD LIGAMENTS PER VAGINAM INCLUDING THE UTERINE ARTERIES FOR FIBROIDS OF THE UTERUS.—Dr. Augustin H. Goelet, of New York, in a contribution to the *American Medico-Surgical Bulletin*, June 1, reports favorably upon this operation in his hands for the control of uterine hemorrhage and reduction of fibroid growths. He believes it should be done in lieu of hysterectomy when that operation would involve too great a risk, and as a preliminary step with a view of avoiding the necessity of the more hazardous operation. When extensive attachments have not been formed which afford additional nutrition considerable reduction has resulted even in growths of large size. When the operation has been done for smaller growths the result has been more satisfactory. In some instances complete atrophy has been reported. This result, as well as arrest of the uterine hemorrhage, is accounted for by the diminished nutrition furnished the uterus and those growths by interference with the blood supply and nerve supply which are included by ligation of the base of the broad ligaments. It is estimated that the uterine arteries furnish the uterus with two-thirds of its blood supply and it is reasonable to expect that a profound effect will be produced upon that organ and growths arising from the walls if this is suddenly cut off.

The sole danger in the operation is the risk of including the ureters in the ligatures, as they pass down behind the uterine arteries only half an inch from the cervix and are consequently in the field of operation. Dr. Goelet suggests, as a preliminary step, to eliminate this risk, that bougies be passed into the ureters through the bladder. He admits, however, that a careful operator accustomed to working in this region may easily avoid the ureters.

The technique of the operation as described by Dr. Geolet shows an important departure from the usual method followed. Instead of ligating each artery in only one place on a level with the internal os, he applies a second and often a third ligature to the artery on each side as it ascends along the side of the uterus, the result of which is to cut off the compensating blood supply from the ovarian artery to the lower part of the uterus.

Dr. Goelet gives all the credit of priority to Dr. Martin, of Chicago, who has recently suggested and popularized the operation and perfected its technique, but states that he first ligated the uterine artery *per vaginam* on one side in January, 1889, in the case of a large fibroid the size of a seven months' pregnancy with a view of diminishing the size of the growth by reducing the blood supply. The artery on the other side was not ligated because the position of the tumor made it inaccessible. Six months later the tumor was one-third smaller, and was giving no inconvenience.

He quoted his last case operated upon to show how promptly uterine hemorrhage may be controlled by this operation.

* * *

SUCCESSFUL OPERATION FOR CEREBRAL ABSCESS.—Dr. Max Scheier has recorded a case of cerebral abscess of peculiar character in the *Berliner Klinische Wochenschrift*, an abstract of which appears in the *Lancet*. The patient was a youth aged nineteen, who since the age of six had suffered from otitis media and deafness on the right side. The discharge ceased for about a year, but had recommenced about three weeks before his admission to hospital, and became in a short time very abundant and offensive. There were headache, fever and constipation. The patient on admission was dazed; there was considerable sleepiness, with some stiffness of the neck and retraction of the head. There was tenderness in the mastoid region, the pulse was irregular, and the temperature raised. The patient was trephined and it was soon evident that there was extensive purulent pachymeningitis. The dura was of a grayish green color and covered with a thick fibrinous deposit. Bone was removed as far as the diseased condition of the dura extended,

but as it pulsated all over it was not opened. A few hours after the operation the temperature fell, and on the next day the mind was clear and the stiffness of the neck had gone. But in a week's time, during which the wound progressed favorably, the patient became emotional and talkative, and a condition of boulimia was manifested. Later there was a sudden discharge of offensive pus, but no change of temperature. A second operation was carried out and the dura mater opened at a point at which there was bulging and an absence of pulsation. An abscess as big as a hen's egg was evacuated. It was situated in the inferior parietal convolution. The boulimia ceased at once, and the psychical condition cleared up and became normal. Healing of the wound took place rapidly, and in a few weeks the patient was discharged completely cured. The result of the operative treatment in what seemed at the first operation to be an unpromising case must be regarded as highly satisfactory.

* * *

Hysterical Apoplexy.—Bischoff, in the *British Medical Journal*, reports a case in a man, aged 28. Some fourteen days after severe mental anxiety, he suddenly became unconscious. On the next morning he regained consciousness, but was found to have complete left hemiplegia and hemi-anesthesia including the conjunctiva. He was quite aphasic and innervated his face muscles imperfectly and slowly. There was no trace of spasm about the face. On the next day it was noted that the movements of the left eye were considerably limited when the right eye was covered up. He soon began to regain power in the leg. The plantar reflex was absent, and the left knee jerk less than the right. About the seventh day the patient again lapsed into a comatose condition lasting for two hours and a-half. Clonic spasm was noted on the next day in the platysma and sterno-mastoid muscles. He steadily recovered power, but the anesthesia and eye symptoms persisted. A temporary weakness in the left arm again appeared, and the contraction of the field of vision became more marked. The patient ultimately recovered almost completely. The author remarks that the involvement of the face and tongue is rare in these cases, and that Charcot's statement that hysterical affections in the face region regularly appear in the form of spasm is not borne out here. The diagnosis was certain on the third day—the left hemiplegia, the deviation of the tongue to the right, the aphasia with perfect power of writing, the hemi-anesthesia including the mucous membranes, the diminution in the field of vision all pointing to hysteria. The affection of speech in hysteria is mostly mutism; here the patient could phonate, but not articulate. Any anatomico-pathological explanation of the eye symptoms was hardly possible. The author maintains that the one-sided lesion was primary, and the unconsciousness secondary, and that it was not an example of hysterical stupor followed by paralysis; nor was it an instance of hysteria complicating organic disease.

* * *

The Influence of Animal Experimentations on Medical Science.—Dr. A. L. Loomis (*Boston Medical and Surgical Journal*) concludes his address before the Congress of American Physicians and Surgeons as follows:

From this history it seems evident that most if not all of the real advances in medicine have been made possible through experimentation. So long as the moral and spiritual development of mankind remains the supreme purpose of creation, medical science can claim equal honor with the science of God, and in the conflict with physical evil must be the first to meet the foe. Until Infinity repeals the edict which gave man power over all created things, the right to claim the services of the brute can never be denied him who devotes his life to the service of mankind. From the ignorant we expect to receive only censure; but from those who in the valley of the shadow of death have learned to know what manner of men we are, I have faith to believe that the reply will come, "We have trusted you with the lives of our loved ones, we entrust to you God's dumb creatures."

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See also Publishers' Department, Page 198.

BALTIMORE, JUNE 23, 1894.

Diet of the Nursing Woman.

THE nursing woman, who is gradually becoming a creature of the past, has received a few words of attention from Dr. Jerome Walker, of Brooklyn, in the *Archives of Pediatrics*. Dr. Walker very properly insists that breast feeding when the nurse is not pulled down by it and the child thrives as it should, is the best feeding a baby can have. As we rise in the social scale there is greater disinclination on the part of the mother to nurse her own child and as a result the American market is flooded with so-called baby foods.

Some women cannot nurse their children, and some will not, and of the former class many would if they could, and the physician can be of great assistance in these cases.

Various foods are recommended and given by the laity to increase the milk in the nursing woman, but the best by far is cow's milk, which is quite effective when mixed with ginger, in the proportion of one to two teaspoonsful of ginger to a tumbler of milk. This is especially advised at night, when the woman is exhausted and needs food that will be easily assimilated. This will not do for all women alike. Some demand one kind of food and some another. There is, however, one form of food to be avoided and that is malt liquors, which are so liable to do harm when taken in excess, for they almost universally increase the quantity of the milk at the expense of the quality and increase the adipose tissue of the woman too rapidly. Tea and gruels consumed in large quantities, especially among the poor, may set up gastro-intestinal disturbances and indigestion.

One of the principal causes of the decreasing power of the American woman to nurse her child is lack of nerve energy from late hours, nervous excitement and such causes. The tendency to avoid the responsibilities of motherhood is in a great measure due to the fact that the young girl and the growing woman are not taught their duties to their offspring. Children should be taught to nurse at regular intervals so that the nurse or mother may have the required rest. Nursing women do well at the seaside, and the children with them can hardly fail to feel the good effects of the bracing salt air. If more attention were paid to the diet and care of the nursing woman there would not be so many fatal cases of diarrhea and other gastro-intestinal diseases. The food of a nursing woman, then, should be: First, palatable, else it will not be readily taken, or if taken will not be as easily digested as food taken with a contented mind; second, it must be easily digested; third, it must be varied in character; fourth, it must be so prepared and cooked that the nourishment and energy it is meant to convey will be obtained from it. And all this presumes a knowledge of dietetics on the part of physicians, one of the studies which has not attained its proper recognition in our medical schools and only in part in cooking schools.

* * *

The Modern Treatment of Anemia.

THE therapeutics of some forms of anemia have changed in the past few years and the inorganic substances, such as iron, seem to be giving way to the organic. Glycerine extract of thyroid has been used with great success, particularly in cases of anemia, and while the

extract must be continually given, it certainly has the effect of improving the patient's health and reducing the swelling. The best way to give it is to use hypodermic injections of the glycerine extract in doses of one c. c. every other day, until improvement is well marked, when the interval between the doses may be lengthened, but the treatment must be continued.

Another substance of great value in anemia, especially of the pernicious variety, is extract of bone marrow, and many writers have reported very brilliant results with this therapeutic agent. The heads and other parts of the long bones of recently killed animals are thoroughly broken up and digested in glycerine for several days and then the whole is filtered. In teaspoonful doses this is said to very effectively improve and even to cure cases of anemia.

The great objection to these animal extracts lies in the fact that they form excellent culture media for pathogenic bacteria and unless they are frequently made fresh or are well protected, there is great danger of introducing disease germs into the system. The results, however, in carefully selected cases and with reliable matter, seem to justify further use. The preparations should be honestly made and contain nothing except what is expressly stated in the formula.

* * *

The Limits of Physical Diagnosis.

To make a correct diagnosis requires an examination from all points of view. The man who relies on physical diagnosis alone in examinations of the heart, for example, may be misled into a false deduction, while he that studies expression, respiration, pulse and other aids is far less likely to go wrong.

Dr. Frank W. Jackson has shown in the *New York Medical Journal* what some of the difficulties of physical diagnosis in heart diseases are. The tyro and even at times the more skilled judgment will interpret a systolic apex murmur as a mitral regurgitation with no further examination, while the more prudent man will reserve his decision until the case has been seen several times and until other signs and symptoms have confirmed or opposed this diagnosis.

The mechanism of the opening and closing of the cardiac valves is usually so exact that no abnormal sounds are heard, but it is very easily conceivable and it is within the experience of many that excitement or some such cause may throw the heart temporarily out of gear and a murmur may be heard which at another time is absent. These evanescent or vanishing murmurs should be carefully taken into consideration before final judgment on a case is pronounced.

Again, the common teaching is that certain normal or abnormal sounds are heard within certain areas over the heart, but even these statements, which are the results of experience, may not alway hold good. A mitral systolic murmur may be suspected when the pulse may lead one to diagnose an aortic lesion.

Instances may be multiplied indefinitely, but the general advice is not to make a diagnosis on the murmur or on the results of physical diagnosis alone, but to examine carefully all the other signs and symptoms, weigh each one and take time in giving the diagnosis and prognosis, especially if it be an unfavorable one. Too great reliance on any one diagnostic means may lead to mistakes and tends to narrow-mindedness.

* * *

Registration of Physicians in Maryland.

THE passage of the new medical practice act was effected after strenuous efforts on the part of the Medical and Chirurgical Faculty and prominent members of the profession, and the next important step is to obtain a complete registration of qualified practitioners in the State. So apathetic is the profession in carrying out these provisions that in Baltimore alone, where the act is so simple and easy, not one-half the physicians have taken the trouble to go to the clerk of the circuit court and spend five minutes in registering.

Some think it wholly unjust to compel all to undergo a supervision, as it were, and perhaps not a few resent this law or are too careless to carry out its requirements, thinking that the penalties will not be inflicted on them; but when the first of July has passed, the time within which all physicians are compelled to apply for registration, then there will be no course left but to prosecute all delinquents.

Let every physician, then, help to elevate his profession and keep its ranks up to the proper standard by adhering to a law which is aimed at nothing but the suppression of quackery in the State and the protection of the profession and the people.

MEDICAL ITEMS.

Cholera is diminishing in Turkey.

Dr. and Mrs. J. J. Chisolm have sailed for Europe.

Yellow fever is still very prevalent at Rio de Janeiro.

Dr. and Mrs. George H. Rohé have returned from Europe.

Professor Romanes, F. R. S., the celebrated biologist, is dead.

Dr. Francis T. Miles expects to spend the summer in Europe.

Dr. Joseph S. Garrison, of Easton, Maryland, was married recently.

London is taking steps to suppress the street-crying nuisance.

The bubonic plague is prevailing among the natives at Canton, China.

Small-pox seems to be dying out in places where it has been prevalent.

Mr. Gladstone has had his cataract extracted by Mr. Nettleship, the oculist.

A special meeting of the Virginia Medical Board was held June 19, 20 and 21.

Dr. Edmund Andrews, of Chicago, recommends nickel steel for surgical instruments.

Dr. Leonard Bell is resident physician at the Emergency Hospital at Washington, D. C.

The International Exhibition of Hygiene at Boulogne in July will be a very brilliant affair.

Vessels bound for Baltimore now come up without detention at the quarantine station at Cape Charles.

Dr. Ridgely Warfield leaves for the Blue Mountain House next week, where he is resident physician.

The Baltimore General Dispensary and Northeastern Dispensary held their annual elections last week.

Dr. I. J. Woodward has resigned as resident physician at the Baltimore University School of Medicine Hospital.

Mrs. Robert Garrett has given money to erect a sanitarium for the sick children of poor parents in Baltimore.

There is much interest shown in the election of a successor to the late Dr. Wm. B. Towles, Professor of Anatomy in the University of Virginia.

St. Lukeland Sanitarium, which is under the auspices of the Hospital Relief Association, for poor women who need recreation, is open for the summer.

The University College of Virginia, at Richmond, will open in the autumn with a large class and a sufficient number of new appliances and improvements to insure a prosperous year.

Dr. Isaiah Dewling, past assistant surgeon United States Navy, and a graduate of the University of Maryland, class of 1860, died recently in Baltimore in the fifty-fifth year of his age.

Dr. John N. Upshur was elected Professor of the Practice of Medicine, and Dr. J. Page Massie, Professor of Pathology and Bacteriology, at the Medical College of Virginia in Richmond.

Lewellys F. Barker, M. B., Toronto, now Fellow in Anatomy, has been elected Associate in Anatomy in the Johns Hopkins University and Dr. B. Meade Bolton, Associate in Bacteriology.

Health Commissioner McShane is very energetic in the inspection of foods. Many cans of milk and several hundred pounds of beef have already been confiscated and a few sweat shops have been closed.

The Children's Fresh Air Society, whose object is to give a short outing to poor children, has begun its summer work. Deserving children are entertained by charitably disposed farmers throughout the State. Physicians in the counties would be doing a kindness by making this known.

The new officers in the Pennsylvania State Medical Society are: President, Dr. John B. Roberts, of Philadelphia; First Vice-President, Dr. S. C. Stewart, of Clearfield county; Second Vice-President, Dr. J. A. Lippincott, of Allegheny county; Third Vice-President, Dr. J. H. Wilson, of Beaver county; Fourth Vice-President, Dr. R. Armstrong, of Clinton county; Secretary, Dr. William B. Atkinson, of Philadelphia; Assistant Secretary, Dr. H. G. Chritzman, of Franklin county; Treasurer, Dr. G. B. Dunmire, of Philadelphia.

BOOK REVIEWS.

INTERNATIONAL CLINICS. A Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Genito-Urinary Surgery, Gynecology, Ophthalmology, Laryngology, Otology and Dermatology. By professors and lecturers in the leading medical colleges of the United States, Great Britain and Canada. Edited by Judson Daland, M. D., Philadelphia, Instructor in Clinical Medicine and Lecturer on Physical Diagnosis in the University of Pennsylvania; Assistant Physician to the University Hospital; Physician to the Philadelphia Hospital and to the Rush Hospital for Consumption. J. Mitchell Bruce, M. D., F. R. C. P., London, England; Physician and Lecturer on Therapeutics at the Charing Cross Hospital. David W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland, Professor of Practice of Medicine in the University of Aberdeen; Physician to, and Lecturer on, Clinical Medicine in the Aberdeen Royal Infirmary; Consulting Physician to the Royal Hospital for Diseases of the Chest, London. Volume I. Fourth series. 1894. Royal 8 vo. pp. xii.–363. Philadelphia: J. B. Lippincott Co. 1894.

This volume, which is quite up to the standard of the others of the series, opens with a short sketch of the life of Charcot. With very few exceptions, the articles are clinical lectures and are certainly very instructive reading, containing much that is not found in the ordinary text-book. The publishers are very liberal with illustrations.

THE NURSE'S DICTIONARY OF MEDICAL TERMS AND NURSING TREATMENT. Compiled for the Use of Nurses and Containing Descriptions of the Principal Medical and Nursing Terms and Abbreviations, Instruments, Drugs, Diseases, Accidents, etc., Encountered in the Ward or Sick-room. By Honnor Morten. Philadelphia: W. B. Saunders. 1894. Price $1.00.

The Nurse's Dictionary is not only a very handy volume, but it contains many definitions and even careful directions under some of the heads. It is only intended as a work of reference at the bedside.

RECENT STUDIES IN SEA-SICKNESS. By Winslow Warner Skinner, M. D. (Par.), Formerly Ship's Surgeon on several Transatlantic Lines, etc. Reprint from the *New York Medical Journal*. New York: D. Appleton & Co., 1894. Pp. 48.

This is a very timely little brochure, when so many physicians have patients who are going on the sea. Unfortunately the method of treatment suggested is one that can only be carried out by a physician. His drug treatment consists in the hypodermic injections of atropine and strychnia in small doses and combined with certain dietetic and hygienic rules, which are doubtless of great efficacy in the author's hands and which might be used in cases where the physician accompanies his patient on the ship and is not too ill himself to carry out this treatment.

THE CARE AND FEEDING OF CHILDREN. A Catechism for the Use of Mothers and Children's Nurses. By L. Emmet Holt, M. D., Professor of Diseases of Children in the New York Polyclinic; Attending Physician to the Babies' Hospital, and the Nursery and Child's Hospital, New York. New York: D. Appleton & Co., 1894; pp. 66; price 50 cts.

This book is the outcome of the author's lectures in the Training School for Nurses, and contains the questions which he formulated for the nurses. They are in most cases very clear, but in some places rather brief. The book should be very useful to the intelligent nurse or mother, and the price makes it within the reach of all.

A MANUAL OF INSTRUCTION IN THE PRINCIPLES OF PROMPT AID TO THE INJURED. Including a Chapter on Hygiene and the Drill Regulations for the Hospital Corps, U. S. A. Designed for Military and Civil Use. By Alvah H. Doty, M. D., Major and Surgeon, Ninth Regiment, N. G. S. N. Y., etc. Second Edition, revised and enlarged. New York: D. Appleton & Company, 1894. Pp. xvi–304. Price, $1.50.

The principal changes in this edition are a chapter on Hygiene and one on Transportation of the Wounded. The other chapters have been revised and brought down to our present knowledge.

FUNNY BONE. A Book of Mirth for Doctors, Druggists, Dentists, Medical Students and Others. By Dr. L. Crusius, Ph. C.; Funny Bone Publishing Co., St. Louis, Mo. Price 50 cts.

This is a collection of very common and indecent jokes (?) which would find its most fitting place in the waste basket.

REPRINTS, ETC., RECEIVED.

The Therapeutic Uses of the Salts of Cesium and Rubidium. By Theodore W. Schaefer, M. D., Kansas City. Reprint from the *Medical News*.

The Electrical Treatment of Fibroid Tumors. By G. Betton Massey, M. D., Philadelphia. Reprint from the *Journal of the American Medical Association*.

Certain Erroneous Principles and Methods in Gynecology. By G. Betton Massey, Philadelphia. Reprint from *Annals of Gynecology and Pediatry*.

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NOTES.

MALAKIN is recommended as an antipyretic, antineuralgic and antirheumatic. It is a salicylic derivative.

*

GLYCERINE is highly recommended as a dressing for the umbilical cord. It is antiseptic, and has also a distinct effect in promoting cicatrization.

*

FOAMING tooth washes should be avoided as indicating the presence of soap which is injurious to the gums. Precipitated chalk is the best of all dentifrices.

*

AN ointment of 60 grains of oleate of tin to 1 oz. of oint. of rose water is an elegant and efficient application to the finger nails when brittle or marked with spots and ridges.

*

DULCIN, described as an aromatic urea derivative—paraphenetol carbamide—and allied to phenacetine, is said to be sweeter than and superior to saccharin and it is indicated in diabetes and other conditions.

*

THE hydrochlorate of scopolaminine in solutions of 1 to 2, to 4 to 1000, is a safe and rapid mydriatic, possessing decided advantages over atropine, in not causing dryness of the throat, and it may be used every hour if necessary.

READING NOTICES.

Celerina.—Headache in childhood is rapidly relieved by Celerina in doses of ten minims four times a day.

*

Trional.—In the administration of Trional the best results are obtained by giving the drug dissolved in hot water, soup, beef tea, etc., shortly before retiring.

*

Sulfonal has long passed the experimental stage and is now esteemed as one of our best hypnotics. The qualities, which render it a desirable sleep-producer, are its reliability and safety, its efficacy in a large variety of conditions of sleeplessness, the facts that it is practically free from the danger of a habit and that the sleep produced by it closely resembles normal sleep, and possesses none of the disagreeable features of sleep produced by narcotic drugs.

*

Sennine.—Since the introduction of "Sennine" to the profession, I have been using it in all appropriate cases, and with such satisfactory results that I cannot refrain from recommending it as being valuable for the purposes claimed by the manufacturers. In vaginitis and leucorrhea it is admirable, and it has proved especially efficacious in pruritus. An especially obstinate case of the latter with a pregnant woman yielded after resorting to every method that had suggested itself to the writer. Improvement set in at once in this case with the use of Sennine.—M. Yarnall, M. D., St. Louis Mo.

*

Antikamnia.—In the April, 1894, number of the *Universal Medical Journal*, the companion publication to the "*Annual of the Universal Medical Sciences*," a magazine covering the progress of every branch of medicine in all parts of the world, and both edited by Chas. E. Sajous, M. D., Paris, France, we find the following notice of antikamnia extracted from an article by Julian, which originally appeared in the *North Carolina Medical Journal:* "The importance attached to this drug, I think, is due to its anodyne and analgesic power, and the celerity with which it acts. As an antipyretic in fevers, it acts more slowly than antipyrine, but it is not attended with depression of the cardiac system and cyanosis. Whenever a sedative and an analgesic together is indicated, this remedy meets the demand. In severe headaches it is the remedy *par excellence*.

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ORIGINAL ARTICLES.

SYNOPSIS OF PRESIDENT'S ADDRESS

Before the American Medical Association, San Francisco, Cal., June 5, 1894.

By James M. Hibberd, M. D., LL. D.,

Richmond, Ind.

At every annual meeting the Permanent Secretary and the Treasurer have difficulty in appeasing delegates who are not received, because the credentials presented by them have not been issued by a society entitled to representation in the Association. The difficulty lies in the fact that some of the State societies are not representative bodies, and consequently the constitutional provision cuts off all delegates from such States except those commissioned by the State society itself. While this is the letter of the law, it is not the spirit that animates the organization of the Association. The constitution should be revised in this particular, at least; every county society in each State should be represented in its State society. In this connection I desire to lay before you some thoughts touching the arrangement of subordinate medical societies in their relation to the American Medical Association.

Every medical man who belongs to any medical society should belong to a county, or an equivalent, medical society, and every member of a county society should be *ipso facto* a member of his State society, and this should be an open sesame to the American Medical Association. By this arrangement all reputable physicians in the United States would be brought together in the common fold, whose power for good within its legitimate sphere would be limited only by its aggregate wit and energy. Such a consummation would elevate the American profession to a plane for useful work the highest conceivable for the disciples of scientific medicine. A sentiment seems to be current among some of the members that indicates a misconception of the character and personnel of the sections, as I view them, regarding the propriety of conferring on the Business Committee the functions of the Nominating Committee. They say, "The Business Committee is made up of the ex-chairmen of sections; the sections are in the hands of the specialists; the specialists reside in the greater cities, and consequently the Business Committee will be constituted of special practitioners who come from the cities, some of which are large enough to furnish half a dozen chairmen at once. This will not only exclude general practitioners from a voice in the selection of officers of the Association, but may, by chance or design, place the general business of the Association under the management of specialists from a few important cities of the country."

The error of this representation is the fact that its entertainers fail to recognize that the aggregate membership of the sections at each annual session is the

total membership of the Association in attendance. True, in each section there will be members of the special society whose work is the same as that to which the section is devoted, and there will be others whose engagements are limited to the same line of practice; but these combined, except in two or three sections, will not number more than a small minority, probably not a tenth of those enrolled in the section. The other nine-tenths will be general practitioners, whose professional proclivities have directed them to the section; and these general practitioners have the power by their votes to elect the best man in the section to its chairmanship, without inquiry whether he lives in a big city or in a hamlet; and in so doing will make it patent to every thoughtful mind that the personnel of the Business Committee will be selected under conditions to insure as intelligent, as well distributed, and trustworthy a committee as the Association can secure. Moreover, the function of a Nominating Committee is to nominate, not elect; confirmation or substitution is in the authority of, and always exercised by, the Association. I am led to present this subject in this light and to this extent, because I feel that a majority of the members recognize the imperfections of our present mode of selecting the Nominating Committee, and realize that the welfare of the Association calls for a committee to exercise the important functions of the Nominating Committee, which has elements of permanency in its organization, and whose personnel has been selected with something of deliberation. The Chairman of the Committee on Military Affairs at Washington has concluded there is a surplus of assistant surgeons, and in his report to the House reduced the number from one hundred and twenty-five to ninety. This recommendation has passed the House, and if it should be approved by the Senate will greatly embarrass the medical service of the army, and in the end be a detriment to the country. Let the American Medical Association at once call the attention of Congress to the mistake threatened. An effort should be made by this Association to restore a part of the appropriation for the support of the National Medical Library, which was dropped by the last Congress. For twelve years the appropriation was $10,000, but the last Congress reduced it to $7000, and the present Congress proposes to continue the reduction still more. The desirability of supervision of public health by the general Government has been recognized by this Association for many years, and manifested in various ways. Various sanitary organizations have entered Congress with petitions, asking that the general Government be clothed with authority to execute measures to assist in protecting public health. The outlook at this time for securing a Bureau of Public Health during this session of Congress is not encouraging. At present there is no measure formulated in this behalf.

So worthy of support is the New York Academy bill now in Congress, it seems to me the reasonable duty of this Association at this time to declare and proclaim its unabated faith in the virtue of vaccination to protect from small-pox, to render persons as immune against variola as an attack of variola itself, and that it is innocent of all mischief when the vaccination is done by a vaccinator who is a competent judge of both the purity of the virus and the fitness of the vaccine.

Much has been done in advancing the extent and character of the collegiate instruction of medical students. Certainly the Association has ground to congratulate itself on the fruits of its persevering labors to secure more thorough medical education. The Congress of Medicine in the immediate future must be along biological lines; the microscope has revolutionized our knowledge of the world of living things, and to us have been discovered the generators of the most extensive, persistent, and malignant epidemics that periodically decimate the earth, as well as intractable and fatal disorders that are always with us. Another line of biological workers have carried us back through the morphology of organs, tissues, and cells, to the origin of vital activity in protoplasm, and still more important, in doing so have given us glimpses of the origin and de-

velopment of the somatic mind that will, when the scheme of nervous organization and function shall be clearly portrayed, dissolve the mystery that has in the past obscured our realization of the true nature of hypnotism, Christian science, and other anomalous neuroses which the sciolists, and in an especial manner those claiming to be doctors, are promulgating and practicing, to the discredit of true scientists and to the injury of the weak-minded and ignorant classes.

We should apotheosize protoplasm, the dividing line between organic and inorganic matter, itself at once the result of the law of perpetual motion with which the Creator endowed the atoms of elemental matter, and the beginning of that phase of energy known as vital activity which constitutes the entire vegetable and animal kingdom. No one people or class of people can claim exclusively to have opened the way into this more primitive arcanum of nature. The physicists of all nations, botanists, zoölogists, anatomists, physiologists, and their congeners, have all participated in this progress. The distinction of Schwann, Virchow, Ferrier, Jackson, Pasteur, Koch, and Sternberg is due to their advanced study of biology.

It is apparent to all who have given attention to the matter of remodeling the constitution, that there is much feeling among the members who have been active in working up the changes that will be offered as a substitute for the constitution as it now exists. It is right that a fair and unbiased expression of the will of the Association, according to the method prescribed by our laws, should be secured; and in so doing there is nothing to excite passion nor interfere with that calm deliberation that distinguishes the proceedings of an assembly composed of cultured and refined people seeking the welfare of the guild to which they belong. And so with the code of ethics; for years there has been a feeling among many most excellent and intelligent working members of the guild, that the code did not fairly accord with the demands of the advanced profession in their intercourse with each other, nor with the proper reciprocal relations between the profession and the public; while, on the other hand, many members, equally intelligent and devoted to the Association, have felt that the code of ethics that has guided the Association through nearly half a century prosperously and honorably, and which is still a reliable guide in every advanced thought and action, cannot be bettered for our present status, and should not be disturbed.

Touching the sufficiency of the constitution and code of ethics of the American Association as they are now, I have well settled convictions, the result of many years' observation, experience and reflection; but I am not here to proselyte my opinions. As I interpret my mission on this occasion, it is to exercise my influence and use my authority to secure to those here entitled to vote a clear expression of untrammelled judgment, and to encourage a cheerful acquiescence of all parties in whatever conclusion may be reached.

Ovariotomy in Pregnancy.—Lebedeff (*British Medical Journal*), has operated five times on pregnant women. In his cases the cyst was multilocular in 1, unilocular in 2, bilateral dermoid in 1, and developed in the broad ligament in 1; all 5 recovered. In 2 pregnancy went on to term, 3 aborted between the fifth and fifteenth day; 204 cases of ovariotomy in pregnancy have been performed in Russia; 21 could not be followed up so as to ascertain the continuation of pregnancy; in 7 the uterus was wounded, 2 of these cases dying; of the remaining 176 cases, 164 recovered completely, pregnancy continuing to term in 122, whilst 12 died.

The Treatment of Confluent Variola.—Dr. S. W. Burson, in recording his experience in the treatment of small-pox during the epidemic in Chicago, writes to the *Medical News* that ichthyol painted with a brush on the back and covered with absorbent cotton will completely destroy the organisms of the disease in that place, lower the temperature, control the itching, lessen nervousness, and slow the pulse and respiration.

THE NERVOUS SYSTEM IN DISEASE AND THE PRACTICE OF MEDICINE FROM A NEUROLOGICAL STANDPOINT.

Read Before the American Medical Association, San Francisco, Cal., June 5, 1894.

By C. H. Hughes, M. D.,
St. Louis, Mo.

In this age of pre-eminent progress in every department of human research, I congratulate you on the onward march Medicine has made and is yet making towards the mitigation of human misery and the mastery of disease, and especially on the part American Medicine has taken in the scientific triumphs of the closing century over the encompassing elements and environment adverse to man's health and strength and consequent happiness and efficiency in the affairs of life. She has made physical and psychical tranquility and power, happiness and length of days, possible to man under the strain and pressure of modern progress. She has searched out and is searching out the causes which are inimical to or promotive of man's strength in the battle of life. She teaches him how to evade the one and to utilize the other, in the power of mind and body.

As our father Hippocrates drove the devotees of superstition from the temple of Hygeia, and taught the people that offended gods could neither bring nor propitiated gods dispel diseases, and as Andreas Vesalius defied the popular prejudice and ecclesiastical power of his day to make his first human dissection, so we, his professional descendants, continue breaking down the barriers of ignorance, of prejudice and superstition in the way of man's happiness and prosperity, unlocking the secrets of nature's arcanum and setting the captive mind and organism free from the enthrallment of disease.

Substitutive inoculations, for establishing tolerance and immunity from other diseases, are spreading the rescuing power of the profession. Consumption, with its 165,000 annual victims in this country alone, will soon be a thing of the past, through wisely applied antisepsis.

Electroscopic and other explorations now penetrate the dark and otherwise hidden places of the human body, making it a glow of light to the diagnostician.

But little, if any, of the human anatomy is absolutely beyond the reach of our science, or relief. The abdominal cavity is no longer a terra incognita to the resources of surgery, thanks to Joseph Lister of London, McDowell of Kentucky, Battey of Georgia, Lane, Gross, Agnew, Frank Hamilton and John Hodgen. The once hidden recesses of the brain, also, are now with impunity penetrated to where our ancestors dared not go, saving lives and minds formerly doomed to destruction, thanks to Fritsch and Hitzig of Germany, Ferrier and Horsley and Macewen, of Great Britain, and Bartholow, of America, the latter having been the first physician in the world to explore and prove the truth of cerebral localization by demonstration on the living human brain.

Science now penetrates to the very dwelling-place of thought and volitional motor impulses in the cerebral cortex, saving by modern neurology and cerebral surgery.

Medical science moves majestically onward in her benefactions, and man, her beneficiary, moves forward to his higher destiny, under her benevolent ministrations.

The grip pneumonia is such as might come from section of the vagi. The vagus largely governs the lungs, the heart and the circulation of the disease, and toxic irritation and depression of the medulla and pons explain most of its symptoms.

The therapeutic lesson of the neuropathic implications of influenza is rest and reconstruction (pending the search after its causative bacteria and their proper bactericide); rest and reconstruction, that phagocytosis may be prompted in the blood, chloral as the best antiseptic, hypnotic and calmative, for even the delirious stage. In the latter, ammonium bromidum added; for the pain, the coal-tar derivative analgesics, and sleep-producing opiate combinations, the elimination of all disturbers and depressors of nerve centers entering through the blood, like the rheumatic and malarial or venereal poison.

It is through the neural connections of the brain and stomach that the acknowledged apepsia nervosa of neurology is a clinical fact. The brain influences the stomach and the stomach influences the brain, but the power of the former over the latter is far greater than the latter over the former. To concede this influence of the nervous system over the digestive processes, we need not ignore any fact of chemico-biological research.

The liver, the kidneys, the bladder and the bowels are similarly influenced by emotion and the lymphatic system is likewise under nervous control like the arterioles by the vasomotors.

A center in the medulla also influences through the chorda tympani nerve and probably the sympathetic, the salivary secretion. A center there also influences the action of the kidneys. The chorda tympani contains secretory and vasodilator filaments. Salivary secretion is induced reflexly by mastication and the irritation of the presence of food in the mouth and stomach and by the vivid remembrance of certain foods whose eating has made an agreeable impression, and by emotion.

We swallow, we digest, we sob and vomit by means of vagus fibers, and its fibers go to the celiac plexus, the spleen, the liver, the kidneys and the small intestine. Œsophagismus, gastrodynia, or cardialgia, tachycardia, palpitation and angina pectoris, and spleen, intestinal, liver and kidneys, are influenced by this wonderful nerve, as well as asthma, and exophthalmic goitre and many affections of the larynx and lower air passages, notwithstanding the complete pathology of this wonderful nerve and of many of the interesting diseases connected with it, may be said to be yet somewhat obscure. The vagus and the vasomotors influence or govern circulation, respiration and digestion.

The dominion of the nervous system over the spleen is one of the concessions of the physiology of our day. Stimulation of the medulla leads to contraction of this organ. Not only its arteries but the organ as a whole is maintained in a state of tonic contraction to a certain extent through the agency of the nervous system.

Hysteria illustrates in an especially forcible manner from the standpoint of clinical observation how suddenly and how extensively nearly all the organs of the body may be profoundly disordered in function by morbid impression through the nervous system. There is a suggestive practical lesson in this "neuromimesis" or mimic neurosis, as to the relation of the nervous system to disease in general. As the study of this disease led Goodell to discern and portray the nerve counterfeits of uterine disease and to say, "The crying error of the day is the mistaking of nerve disease for womb disease." So I say of disease in general, the crying error of the day is the ignoring of neuropathic implications, concomitants and sequences of organic, visceral and general diseases, and the mistaking of nervous and other diseases.

The nervous system regulates the law of rhythm in the animal economy in both its physiological movements and pathological perversions of movement, and this fact affords us, from a neurological standpoint, important hints for the management of our patients and therapeutic suggestions, hints often overlooked in practice.

The *vis medicatrix naturæ* resides in the nerve centers, and in their power to maintain, under stress of invading disease, the normal metabolism in the various organs, and as I believe, though this is not yet susceptible of scientific proof, of the furnishing and multiplying of the phagocytic hosts of con-

servative destruction in the healthy blood.

The Importance of Early Recognizing Neurasthenia.

A great advance was made in clinical medicine when neurasthenia, or as I have called it, general functional neuratrophia, was first recognized and differentiated from secondary exhaustion of the general nervous system, from the autotoxicity of retained excretions and profound physiological brain and nerve and muscle tire.

Neurasthenia, or general functional neuratrophia, shows itself chiefly in the brain and is psychically characterized by timidity of conduct, nervous irritability and morbid fears, bordering on, but not becoming, delusions, and physically by functional atony of the viscera, especially of the stomach, heart, bowels and motor and psychical areas of the brain. It is the cause and source of apepsia nervosa and of cerebro-spinal irritation, and differs from hysteria, with which it is sometime mistakenly confounded, in being continuous and not paroxysmal, and in being far more common in men than in women.

The question of the parasitic origin of this disease was left *sub judice* at the last International Congress at Rome, at the close of the most interesting and learned discussion ever held on the subject.

The same light has lately dawned on gynecology and every department of medical practice. We are approaching an era when the whole patient is to be treated, no more only a part or organ solely, and neurology will have a paramount place in general clinical medicine, notwithstanding the recognized and merited advances of bacteriology in pathogenesis.

Certain Heart Affections Proceed from the Brain.

What is true of the influence of the nervous system over the stomach in dyspepsia, and the lungs in pneumonia of influenza, is also true of its influence in the production of certain diseases of the heart. They come from states of the brain.

When the heart is severed from the central nervous system by section of the vagi nerves, a destruction of the vagus center takes place by traumatism or disease, profound changes in the heart's structure ensue, this points to central trophic influence through the vagi and to the often central nervous origin of heart disease. The regularity of the heart's rhythm from and strengthening of its beat through vagus stimulation and central stimulation, as by certain volatile and internal stimulants, is suggestive.

We are now able to understand how many disorders of the heart are coincident in their inception with occasions of fright and worry and anguish, sudden accesses of extreme ire, disappointment, prolonged enforced vigilance and other brain strains. These, as Mills tersely says, point to influences of a central origin as greatly affecting the life processes of this organ.

As the "medulla oblongata is functionally the ruler of vegetable life," so it governs and influences many diseases, and the physiological and psychic centers of the cortex influence it and the centers below it, as the recto-genito-urinary centers of the cord, etc.

As we recognize psychic influence over our physiological life, over physical and mental habits, so must we come to acknowledge it more generally in our dealings with disease. The physiological law that habit in the psychical life develops to a tendency to recurrence is also exemplified in the disposition of certain diseases to recur and the interrelation between muscular and mental tonus suggest the importance of maintaining the psychical tonus in the treatment of all diseases, and the successful therapeutics of hypnotism proves it in many.

Hemophilia and the Vasomotor System.

The neuropathic source of hemophilia in the vasomotor system is more probable than any asserted dyscrasia of the blood.

To divest ourselves of undue scepticism in regard to the influence of the nervous system in the development of what we are accustomed to call disease, but which is often the sensible patholo-

gical product of a morbid process, we should recur often to the physiological possibilities of the mechanisms of neural control over the arterial system and of sensation and motion.

It is through the nervous system that we may understand how the hair turns in melancholia and may thicken in chronic mania or dementia of the less distressed and more stupid and inactive forms, how its color may turn from dark to white and back again to dark, with the access and recovery of recurrent insanity, how it may gloss and dry, erect or flatten, be lost or regained under mental states, and how the teeth may decay, the bones and nails grow brittle and the skin harsh from the same cause, and how, from neuritis, the nails transform and the limbs waste as well as fail in sensibility and mobility, besides the eczematous, pigmentary and horny changes of the skin from nerve injuries.

High Temperature and Fever Dependent on the Conditions of the Nervous System.

That remarkable phenomenon, the uniformity of the temperature of the human body at all latitudes and in all seasons, is due to regulation adjustment through the nervous system, and when temperature is disturbed it is due to irritation, mechanical, chemical or toxic, of the nervous system, as in traumatic violence, microbe, septic or drug disturbances.

The Nervous System is the Supreme Ruler in the Organism.

When disease enters it is weakened; when death takes place it is dethroned. The germs of malaria, tubercle, cholera, typhoid, tetanus, etc., or the living virus of any fever, make no fatal inroads until they break down and destroy the centers of neural control and resistance.

Whatever view we may take of bacilli, bacteria or cocci which our glass may reveal to us in the damaged organism, whether we regard them as carrion about a carcass, rats forsaking a sinking ship, thieving, destroying, or scavenger parasites, one thing is certain, viz.: disease becomes manifest only after the mechanism of neural sensation; emotion, ideation or control reveal it, for as I have elsewhere said, the nervous system is the central executive and universal sentinel system of the organism. It governs and legislates for the physiological body, exercising, moving, restraining, regulating its inhibitory power over organic processes, in health and disease. It has its subordinate tributary and sustaining forces in the glandular, vascular, osseous and other systems.

A change in the weather or a certain exposure sends one man to bed with rheumatism, another with pneumonia and a third comes down with remittent or intermittent fever or phthisis. We say uric acid in the first case, pneumococci in the second, malaria in the third and tubercle bacilli in the fourth.

And now in the sunlight of advancing science and of the approaching twentieth century, I proclaim that neuriatry and the practice of general medicine are practically one.

The practice of medicine is rapidly becoming one of neurological methods, of neuriatry and psychiatry and the best neurologist, all other attainments being equal, must of necessity make the best general practitioner.

The boon of hypnosis and narcosis under the many methods for its induction known to our art, saving the insomniac from the precipice of mental overthrow or neural failure in the lower centers of the cerebro-spinal axis or peripheral nervous system, the power of antisepsis, and through it the wonderful procedures and possibilities of modern surgery, and this *fin de siècle* hygiene. The many and marvelous therapeutic and hygienic advances in promoting the phagocytosis of the toxic bacteria, the destruction of the ptomaines, and in other directions of relief and cure, the discoveries of pathology, histology, medical chemistry, biology, neurology, psychology, psychiatry and the contributions of surgery, gynecology, ophthalmology, otology, laryngology, proctology and the other specialties of study and work, have made the latter decades of the present century the most memorable in resourceful discovery in the history of medicine or in the history of mankind.

Intravenous injections of immune ani-

mal blood serum promise much for the cure of phthisis and other chronic contagious diseases, and there appears good therapeutic promise for the coming years in mycodermic medication.

[On motion of Dr. Didana, a vote of thanks was tendered Dr. Hughes for his able paper.]

SOCIETY REPORTS.

THE AMERICAN MEDICAL ASSOCIATION.

FORTY-FIFTH ANNUAL MEETING, HELD IN SAN FRANCISCO, CALIFORNIA, JUNE 5, 6, 7 AND 8, 1894.

Specially reported for the MARYLAND MEDICAL JOURNAL.

AT the forty-fifth annual meeting of the American Medical Association, which convened in San Francisco, June 5, 6, 7, 8, inclusive, were assembled six hundred delegates of earnest men and women who had come from all portions of the United States to compare notes and exchange views, with the object of crystalizing the best scientific thought of the age so far as it relates to the science and art of healing. The meeting was presided over by President Hibberd, of Indiana. Several addresses of welcome on behalf of the city and the California medical profession were delivered. Dr. Hibberd was presented with a beautiful gavel emblematic of California, the body being made of manzanita and the handle of orange wood. On either side was a gold plate—one inscribed "A. M. A. S. F. 1894," the other, "Dr. James F. Hibberd, President." The Oregon Medical Society presented each section with a gavel, the mallets of which were of myrtle and the handles of yew.

After a few appropriate words of thanks, Dr. Hibberd delivered the annual address. It dealt with questions of great interest to the audience of fifteen hundred delegates and physicians, and was listened to with the closest interest and interrupted with frequent bursts of applause. Later in the session all the suggestions contained in the address were adopted by the Association. (For Address, see page 199.)

Owing to illness, Dr. Richard J. Dunglison, who has been Treasurer of the Association for a number of years, tendered his resignation. A resolution of thanks to the retiring treasurer with a provision that he be presented with three hundred dollars, was adopted.

Dr. W. B. Atkinson, the Secretary, then read his report, which referred entirely to the one subject that is likely to cause discord in the Association, the proposed change in the Code of Ethics. He reported that so far as heard from the sentiment of the various State societies was as follows: Opposed to change, 21; in favor of a change, 2; laid on the table, 3; not yet considered, 3; no reply, 11.

The Nominating Committee consisting of one delegate from each State was then elected, with Jerome Codman, of Alabama, Chairman.

This closed the first day of the general session, and at two in the afternoon, the regular work of the sections was begun.

SECOND DAY, GENERAL SESSION, JUNE 6.

As soon as the meeting was called to order the special committee on important business, of which Dr. J. N. Quimby, of New Jersey, is chairman, presented the following resolutions, which were unanimously adopted:

Resolved, That the American Medical Association urge upon Congress the advisability of preserving and promoting the efficiency of the Army Medical Department.

Resolved, That any reduction in the present membership of the Army Medical Department or of its appropriation would be prejudicial to the interests of the Army and the country; and be it further

Resolved, That the Secretary be instructed to thus inform Congress by telegraph.

Dr. C. H. Hughes, of St. Louis, editor of the *Alienist and Neurologist*, and one of the most eminent physicians in the United States, was then introduced and delivered the Annual Address on General Medicine. Not only was this address most profound and scientific, but

from a literary standpoint it was a veritable masterpiece of art and was all in all *the* effort of the present session. (See page 202.)

Dr. H. O. Marcy, of Boston, offered a resolution looking to the better unification of the medical profession, in which the various State societies were requested to unite in the establishment of a uniform standard of requirements for admission to the practice of medicine, and to aid in advancing the scientific status of the same, by the appointment of State Boards of Examiners independent of the teaching faculties of medical colleges.

Dr. G. W. Webster, Librarian, in his Annual Report strongly recommended the turning over of the Association's library, now in the Smithsonian Institute at Washington, to the Newberry Library at Chicago.

Both the resolution and the suggestion regarding the removal of the library were referred to the business committee.

Dr. E. E. Montgomery then read the report of the trustees of the *Journal*. Some of the delegates objected to certain new remedies and patent nostrums which have been given space among the advertisements. The matter was hotly contested and after a motion to lay on the table had been lost, the report was adopted by a decisive majority, and the offending portions referred to the Judicial Committee.

THIRD DAY, GENERAL SESSION, JUNE 7.

President Hibberd called the meeting to order, and after the usual announcements by the Chairman of the Committee of Arrangements, the majority report of the Committee on Revision was presented by Dr. Holton. It was essentially the same as the new Constitution prepared at Milwaukee two years ago. The reading was interrupted by frequent bursts of applause which made the non-revisionists look rather serious.

The minority report was presented by Dr. Didana, of New York, and contained the entire old Constitution and By-laws, with some slight changes. By a vote of 161 to 70, the minority report was made the report of the committee and the conservative element was exultant. Dr. Walker, of Virginia, then moved the adoption of the report as a whole. The vote was taken by roll call, and only 215 delegates responded to their names. The vote was announced to be 151 ayes to 64 noes, and as a three-fourths vote is required to change the Constitution, the motion was declared lost, leaving the old Constitution, unamended, remaining in force.

The address on General Surgery by Dr. Earnest Laplace, of Pennsylvania, was read by title.

FOURTH DAY, GENERAL SESSION, JUNE 8.

The meeting was called to order by President Hibberd. The question of the amendments to the constitution was taken up. After a lively contest the consideration of the matter was indefinitely postponed. Dr. Holton, Chairman of the Majority Committee, presented a revision of the Code of Ethics. Dr. Didana, chairman of the minority faction, followed with the report of his committee.

Dr. Ingals' motion to lay the whole matter on the table was carried. Later in the session Dr. Marcy of Boston moved that all matter relating to the Constitution and Code which had been laid on the table be again taken up for consideration. Carried.

He then moved to indefinitely postpone the revision of the Constitution. Carried amid great applause. A motion that a statement making clear the provisions of the Code be published regularly in the *Journal of the American Medical Association* explanatory of the exact position of the revision contemplated, was adopted.

Dr. Wingate, Chairman of the Committee on Establishment of a Department of Public Health at Washington, urged the advisability of endeavoring to put an officer in the Cabinet. In case this could not be accomplished, a national sanitary officer should be appointed.

Dr. Cochran, of Alabama, suggested there should be a conference held at Washington, annually, for the consideration of questions of public health. Both suggestions were adopted.

Report of the Business Committee recommending that members be allowed to go three years without paying dues before they are dropped from the roll was adopted.

A resolution on the death of Dr. Rauch, of Illinois, was presented by Dr. L. Montgomery and unanimously adopted.

A letter from the Minnesota State Medical Society extending to the members of the American Medical Association an invitation to visit the St. Paul Medical Convention on their way east was read by Secretary Atkinson.

Dr. Edward Jackson, of Pennsylvania, introduced a condemnatory preamble relative to certain advertisements appearing in the *Journal* of the Association. The preamble was stricken out, but the following resolution was referred to the Judicial Council :

Resolved, That the various State medical societies in affiliation with this Association are hereby requested to inform this Association whether their members approve the policy of admitting such advertisements as "Antikamnia," "Laborline," etc., to the pages of the *Journal of the American Medical Association*.

A vote of thanks to the medical profession of California for courtesies extended to the American Medical Association was adopted unanimously.

The address on State Medicine by Dr. George H. Rohé, Maryland, was read by title, owing to the absence of the author.

The newly elected President, Dr. Donald McLean, was escorted to the platform. He delivered a short address, replete with the kindest feeling towards the members of the American Medical Association and full of appreciation for the honor and courtesies bestowed upon him.

After a few words of thanks to the Association for the consideration shown him during the past year, Dr. Hibberd closed the session. The place of meeting next year is Baltimore, Maryland.

OFFICERS FOR 1895.

President, Donald McLean, Michigan.

Vice-Presidents, Starling Loving, Ohio; Wm. Watson, Iowa; W. B. Rodgers, Tennessee; F. S. Bascom, Utah.

Treasurer, H. P. Newman, Illinois.

Permanent Secretary, Wm. B. Atkinson, Pennsylvania.

Assistant Secretary, G. H. Rohé, Maryland.

Librarian, passed.

Chairman of Committee of Arrangements, Julian J. Chisolm, Maryland.

Board of Trustees, Joseph Eastman, Indiana; J. T. Priestley, Iowa; John E. Woodbridge, Ohio (unexpired term); J. W. Graham, Colorado (vice D. C. Patterson, deceased).

Judicial Council, D. W. Crouse, Iowa; R. C. Moore, Nebraska; T. D. Crothers, Connecticut; G. W. Gillespie, Tennessee; W. T. Bishop, Pennsylvania; C. H. Hughes, Missouri; I. J. Heiberger, District of Columbia; H. Brown, Kentucky (unexpired term).

Address on Medicine, Wm. E. Quine, Illinois.

Address on Surgery, C. A. Wheaton, Minnesota.

Address on State Medicine, H. D. Holton, Vermont.

Chairman of Committee on Nominations, Jerome Cochran.

Surgery and Anatomy.—Joseph Ranschoff, Ohio, Chairman. Reginald H. Sayre, Secretary.

Practice of Medicine.—E. W. Kellogg, Milwaukee, Chairman. W. E. Quine, Illinois, Secretary.

Obstetrics and Diseases of Women.—C. N. Martin, Chairman. X. O. Werder, Secretary.

Neurology and Medical Jurisprudence.—Daniel R. Brower, Illinois, Chairman. Wm. J. Gavigan, San Francisco, Secretary.

Ophthalmology.—Edward Jackson, Philadelphia, Chairman. H. V. Wurdeman, Wisconsin, Secretary.

Laryngology and Otology.—Dr. J. F. Fulton, St. Paul, Chairman. T. J. Gallaher, Pittsburg, Secretary.

Materia Medica and Pharmacy.—Prof. Welpley, St. Louis, Chairman. G. F. Hanson, San Francisco, Secretary.

Physiology and Dietetics.—Dr. E. H. Woolsey, Oakland, Chairman. Chas. G. Chaddock, St. Louis, Secretary.

Diseases of Children.—E. H. Small, Pittsburg, Chairman. G. W. McNeil, Pittsburg, Secretary.

State Medicine.—L. H. Montgomery, Chicago, Chairman. C. H. Sheppard, Brooklyn, Secretary.

Dermatology and Syphilography.—A. E. Regensburger, San Francisco, Chairman. D. H. Rand, Oregon, Secretary.

Oral and Dental Surgery.—M. H. Fletcher, Ohio, Chairman. E. S. Talbot, Chicago, Secretary.

Officers of the Association of Medical Editors for 1895:

President, J. B. Hamilton, Chicago.

Vice-President, G. F. Gould, Philadelphia.

Secretary, M. B. Ellis, California.

The American Medical Temperance Association session was interesting and well attended. Dr. T. D. Crothers, of Hartford, Conn., read the $100 prize essay by John Davis Kates, of Chicago, entitled "The Effects of Ethyl Alcohol on the Oxygen of the Blood," also the address of Dr. N. S. Davis, Chicago, President of the Association.

Dr. J. W. Quimby, New Jersey, and Dr. H. A. Sanderson, of Helena, Montana, spoke eloquently for temperance from a medical standpoint.

Upon a motion of Dr. Crothers, a resolution was adopted that associate members might be admitted to full membership upon the payment of the annual fee of one dollar.

Officers elected for this year were Dr. N. S. Davis, Chicago, President, Dr. T. D. Crothers, Hartford, Secretary.

The American Medical College Association met at the Palace Hotel and elected Dr. E. Fletcher Ingals, of Chicago, and Dr. Perry S. Millard, of St. Paul, Secretary and Treasurer for the ensuing year.

A resolution was adopted advising that all medical colleges connected with the Association, commencing with 1895, require attendance upon four annual courses of lectures of at least six months' duration as a condition requisite for eligibility to graduation, and all students, before they be admitted to medical classes, must present a diploma from a recognized university or college, or in the absence of a diploma or certificate, sustain a thorough examination in all the branches of a good English education.

MEETINGS OF SECTIONS.

SECTION ON MEDICINE.

FIRST DAY, JUNE 5, 1894.

The various working sections were represented by several hundred members of the Association, including many of the most eminent physicians in America.

The section on Practice of Medicine was presided over by Dr. E. Wells Kellogg, of Milwaukee, Wis., in the absence of the chairman, Dr. H. A. Hare, of Philadelphia.

Dr. D. W. Montgomery, of San Francisco, opened the section with a paper entitled LEPROSY IN CALIFORNIA.

"In all ages and in all countries," he said, "the mass of mankind has believed in the contagiousness of leprosy, and even now, when exposed to the sharpened criticism of scientific inquiry contagion is still the only basis on which we can explain the facts. It is not known how the contagion is carried or how inoculated. We might look upon the presence of leprosy in Chinatown with indifference, thinking of it as simply confined to an alien population, but the possibility of their affections being transmitted to us should make us alive to the importance of warding off the danger. A paper drawing attention to the contagiousness of leprosy, especially when even the laity believe it to be far more virulent than it really is, would seem to be superfluous, but allow me to give you an example of civic carelessness in this very particular.

"Until lately our lazaretto was also our small-pox hospital, and the lepers had the free run of the wards, which were liable at any time to be occupied by small-pox patients. The bed occupied by a variola patient might have been used as a lounging place by a leper a few minutes before. The variola patient was forced into the hospital, and he might be a very decent fellow; as a matter of fact, a physician enjoying a good practice died there a few years ago, and it is not just to put a man in a bed on

which a leper had been taking his noonday nap, thereby exposing him because of a temporary disease to the possibility of contracting a malady that would make him an outcast from society for life. This matter is mentioned rather by way of example than as a complaint, as the management has been changed lately and the discipline is better, but even now we ought to be on the lookout for a lapse of city morals in this direction, for in case of a small-pox epidemic it is to be feared the main building would again be used as a small-pox hospital."

Dr. J. H. Wythe, of Oakland, read a paper on the STRUCTURE OF BLOOD CORPUSCLES AND ITS RELATION TO PRACTICAL MEDICINE, in which he maintained that a microscopical examination of the blood was one of the most important aids in the diagnosis of disease. He called attention to the fact that the blood is not simply an aggregation of corpuscular elements, but that the plasma is capable of exerting powerful influences on the economy. This was particularly noticeable, as regards the bactericidal powers, which he believes to be due to the solvent action of the serum. Changes in the specific gravity, as well as in the acidity and alkalescence of the blood, should be noted as these conditions often pointed to diseased conditions and were probably due to the absorption of certain toxines, ptomaines or leucomaines. He had observed the structural changes occurring in the cellular elements of the blood as a result of morbid processes when closely observed for a long time, and the information thus gained conveyed to his mind the impression that the changes had a definite relation to the diseased conditions. Furthermore, when we consider the various functions performed by the blood, it is not strange that we should have a variety of structure in its cellular components.

Dr. William Watt Kerr read an able paper entitled DIGITALIS IN THE TREATMENT OF PNEUMONIA. After outlining the principal classes of teaching as regards the use of digitalis in this disease, he said :

Digitalis increases cardiac systole by stimulation of the heart musculature and the intra-cardiac ganglia and raises blood pressure. Further, it stimulates the vagi, thus prolonging systole. The depressed cardiac action in pneumonia is due to: 1st. Absorption of toxines and products of tissue waste. 2nd. The pyrexia. 3rd. Obstruction of the circulation through the lungs. Recognition of all the causes leading to depressed cardiac action will point out the importance of prolonging ventricular diastole. Digitalis when indicated always produces good results. Conditions contraindicating its use are: 1st. In persons having fatty or degenerated heart. 2nd. When patient is extremely plethoric, when nitroglycerine should be used instead. While digitalis is beneficial in certain cases, no claim is made for its being a specific. Do not use the drug until there is evidence of cardiac weakness, then give 15 *m.* of the tincture every three hours until the pulse shows evidence of the effect, then reduce the dose sufficiently to hold the heart steady.

In the discussion which followed, the general idea seemed to be that the dose of fifteen of the tincture was too large and that certain reflex actions as nausea, etc., were liable to follow.

SECOND DAY, JUNE 6.

THE INFLUENCE OF ATMOSPHERIC PRESSURE UPON THE PREVALENCE OF PNEUMONIA, by Dr. C. M. Richter, San Francisco.

The author in treating the subject under this caption gave a very learned discourse on the influences of atmospheric pressure in pulmonary diseases. He claimed that pneumonia does not evince a bacillary origin, and that even in well marked cases the specific germ is rarely found. There are several forms of pneumonia; epidemics generally affect children under five years of age and adults over fifty years of age, in greater proportion. The liability to pneumonia begins with zero at the poles and gradually increases to a point in the temperate zone, here again diminishing towards the equator. Winter and early spring show the greatest proportion of cases; summer and early autumn the least. This, according to Dr. Richter, may be

explained by the greater maximum atmospheric pressure during the months when pneumonia is prevalent, or summing up; the greater the continued maximum high atmospheric pressure, the greater the prevalence and mortality of pneumonia. Statistics were quoted covering a number of years, including the large cities of Europe, America and Australia, which went to bear out the speaker; however, in closing he urged a more extensive and thorough line of research with the view of finding the effect of continuous or extreme high atmospheric pressure on the organism.

Fever and the Relations of Micro-organisms to the Disease.

A paper by the above title was read by Dr. Washington Ayer, of San Francisco. The speaker assumed a negative position as to the germ theory, stating that he considered some conservatism necessary in this day of bacteriology. He said fever is an important factor in almost every disease. In its generic sense fever means an exalted temperature of the blood as a result of increased tissue destruction. Mutation and nutrition are interrupted. He called attention to the fact that even the same type of fever shows great variations in different patients, and even in the same individual. From this he concluded that if germs were the *materies morbi* there would be more uniformity. Does convalescence show that the germs have ceased to proliferate, or that they are afraid of the fusillade of remedies fired into their camp? Typhoid fever is generally milder in course on the Pacific slope than on the eastern coast, yet the *casus belli* is claimed as one and the same. Why? In the opinion of Dr. Ayer, one example, viz., intermittent fever, makes the germ theory for fevers untenable. In concluding, the speaker said: More careful work in practical medicine and less in the dreamland of microscopy was needed. At present all the investigations have only proved the existence of organisms.

Tubercular Peritonitis, by Dr. W. F. McNutt, of San Francisco.

Dr. McNutt presented the reports of four cases upon which he had performed laparotomy for *primary* tubercular peritonitis. In all these cases complete recovery took place, which has been permanent. He emphasized the point that from his investigations all these cases were primary—no evidence of a tubercular process in other organs being found. In all four cases the peritoneum was found thickened and covered by thousands of miliary tubercles and in the cavity an exudation varying in character in the different cases. Microscopical examination of a piece of the peritoneum, the site of tubercles, made by Dr. Montgomery, of San Francisco, showed the histological elements to be those of tubercle, although no tubercle bacilli could be detected—however, the macroscopical and microscopical appearance was tubercular.

Another point dwelt upon by the speaker was the peculiar shape of the abdomen noted in cases of tubercular peritonitis with effusion. It resembles that condition found when due to ovarian disease and not that generally found in ascites. This Dr. McNutt attributes to the fact that the peritoneum is enormously thickened.

The Pathology of Tetany, by Dr. John F. Carpenter, Pottsville, Pa.

Dr. Carpenter said that from recent contributions made to the pathology of tetany it is now recognized as a nervous disease. No post-mortem changes have been found to show the exact nature of the disease. A second cause of pathological uncertainty lies in the fact that the disease occurs in various forms, viz.: 1st. Rheumatic, acute or epidemic tetany—generally fatal. 2nd. Chronic, due to chronic diarrhea, prolonged lactation, etc.—recovery usual. 3rd. Occurring in the course of dilatation of the stomach. 4th. Surgical tetany, following removal of thyroid gland especially—generally fatal.

Tetany is found to follow such diseases as produce a morbid discharge from mucous surfaces and due to sepsis. This is especially true of the puerperium when complicated by septic infection.

The speaker, in summing up, said that, in his opinion, sepsis is clearly traceable as the causal agent in tetany. In all the

conditions predisposing to its occurrence septic infection is clearly probable. Furthermore, sepsis and septic absorption will account for other grave nervous disorders, this being due to the fact that blood poisoning by septic material causes a profound anemia, this being the proximate cause of nervous irritation. Several cases, occurring in the practice of Dr. Carpenter, were cited to prove his views. Habit also has an influence. He found attacks of tetany kept up, owing to an unsuitable equilibrium which was set up by the original attack. At the present time, thanks to antiseptic precautions, tetany is but little known, and the speaker expressed the belief that in the near future it would be wholly a disease of the past.

MEDICAL PROGRESS.

Symphysiotomy.—Walcher (*Centralblatt für Gynäkologie*, 1893, No. 25), although not a special opponent of symphysiotomy, believes the operation should be limited to the utmost in its scope. Out of five hundred and fifty births per year in his establishment, reported in the *American Journal of the Medical Sciences*, he has as yet no occasion to perform the operation. In the last year he has had to perform Cæsarean section but once for narrowed pelvis, all the other labors in this class of cases having come to a fortunate end for the mothers and generally for the children. The condition of the symphysis after the operation is also an objection. In many cases there is either a loose joint or ankylosis—both great disadvantages to the patient. The design of the symphysis is to form with the sacro-iliac joint an elastic, springy connection between the thighs and the vertebral column. This is so constructed that the haunch bones and sacrum do not move in one axis, but that the pelvic planes converging from before backward form two co-operating axes, which for the execution of a movement require a sliding of the haunch bones in the symphysis. If the symphysis be ankylosed, the movement in the sacro-iliac joint is lost. When this occurs the jar in walking will be transferred directly to the spine, a most important point in the movements and carriage of the patient. A loose joint in the symphysis lessens safety. Concerning the manifold injuries of bladder and urethra already published, the author believes that even with improved technique not much better results will follow in the future.

* * *

A New Method of Using Cocaine for Local Anesthesia.—Krogius describes in the *British Medical Journal* a new method of producing cocaine analgesia, which is based on the fact that when a solution of this agent is injected into the subcutaneous tissue near to a nerve trunk it causes loss of sensation over a large zone corresponding to the peripheral distribution of this nerve. In order to reach the selected nerve trunk with certainty, and to apply the cocaine to several of its branches at the same time, the author, in injecting the subcutaneous tissue, passes his needle across the long axis of the limb, and as the needle is thrust along, the solution is gradually discharged. An injection made in this way across the root of a finger will, in the course of ten minutes, result in analgesia of the whole digit, not of the skin only, but also of the tendons, the periosteum, and all the deep structures. If one or two injections be made transversely near the wrist, a considerable extent of the palm of the hand may be rendered analgesic. The sensibility of the ulnar side of the hand as far as the roots of the last two fingers may, it is stated, be abolished by injecting a solution of cocaine over the ulnar nerve at the back of the elbow. By injecting over both supraorbital notches, analgesia may be produced in the whole of the middle portion of the forehead. The analgesia caused by this method of using cocaine attains its greatest intensity and extent from five to ten minutes after the injection, and is maintained for a quarter of an hour or even longer. The author injects only a weak (two per cent.) solution of cocaine, and keeps the patient recumbent for at least a quarter of an hour after the operation. This method has been practiced with success at Helsing-

fors in 200 minor operations, such as amputation of the fingers and toes, excision of palmar fascia, and phimosis.

* * *

Hysterectomy in Ectopic Gestation with Disease of the Other Appendages.—Dr. Florian King, in a paper on the above subject in the *New York Journal of Gynecology and Obstetrics*, emphasizes the following points:

1. If you meet with a tubal pregnancy and find the other appendages in such a state that their removal is necessary, it is better surgery to remove the uterus at the same time, thus saving your patient all subsequent trouble.

2. Even if there be a doubt whether a part of the ovary on the other side may be saved, in the presence of such extensive adhesions as will create a large, raw oozing surface on the posterior wall of the uterus necessitating free drainage, it is infinitely better to remove that uterus and secure drainage *per vaginam* than to leave it and drain through the abdomen.

* * *

Piperazine.—A new compound which has been highly recommended as a solvent in uric acid calculi is piperazine, whose chemical formula is $C_4 H_{10} N_2$. It is a synthetical compound and was prepared to replace the active principle, spermine, which was obtained from testicular fluid. Dr. John Gordon, of Aberdeen, Scotland, has made a study of this substance and his observations are printed in the *British Medical Journal*. Piperazine is manufactured by a patented process from the hydrochlorate of ethylenediamine by the action of sodium glycol. It occurs in crystalline masses, is deliquescent, readily soluble in water, is strongly alkaline and has a cool, saline, or slightly ammoniacal, and bitter taste. His experiments were all conducted in the laboratory and as the patented compound is very costly, the Scientific Grants Committee of the *British Medical Journal* defrayed the expenses. His conclusions are as follows:

1. Piperazine is not wholly oxidised in the body, and may be detected in the urine of those to whom it is exhibited.

2. Piperazine in solutions of 1 per cent. in normal urine, when kept in contact at a temperature of 39° C. (body temperature) for a given time, has the property of dissolving to a great extent a fragment of a uric acid calculus.

3. That the stronger the solution of piperazine in urine (up to 7.5 per cent.) the earlier did the solvent action begin and the more rapid was the completion.

4. That, notwithstanding this, with the stronger solutions of piperazine in urine the rate of solubility was not so markedly rapid over the weaker solutions as might be expected.

5. That the solvent action of piperazine in similar circumstances was greater than any other of the substances that were employed, namely, borax, lithium citrate, sodium carbonate, and potassium citrate.

6. That piperazine, in weak and strong solutions in urine, converted the undissolved portion of the calculus into a soft granular or pulpy condition.

7. That neither borax, lithium citrate, sodium carbonate, nor potassium citrate in similar circumstances rendered the fragment of calculus soft or pulpy.

* * *

Myomectomy as a Substitute for Hysterectomy.—Dr. E. C. Dudley, in the *New York Journal of Gynecology and Obstetrics*, gives the following classes of cases where myomectomy should be supplemented by removal of the appendages:

1. Where these organs are the seat of such disease as would demand their removal under other conditions.

2. Where the enucleation of the tumor or tumors has so injured the uterus as to render it incapable of performing its functions, especially where the injury is such as to cause cicatricial atresia of the uterine ends of the Fallopian tubes. This injury might affect the tube on one side only.

3. Where the uterus contains an additional myoma so inaccessible as to make enucleation extra-hazardous.

Dr. Dudley also decries any wish to suggest his operation as an exclusive one but insists upon the frequent necessity of a radical operation for uterine myomata.

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See also Publishers' Department, Page 218.

BALTIMORE, JUNE 30, 1894.

THE proceedings of a body of physicians who number almost four thousand, and many of whom stand high in the profession, cannot but be of general interest to medical readers. The report of their proceedings, which appears in this issue, was necessarily long delayed because of the great distance of the place of meeting.

The American Medical Association.

The American Medical Association, an organization similar to the British Medical Association, is a representative body of physicians from each State, and while the membership is practically unlimited, still each applicant must be endorsed by his State or local society before his name will be considered. The membership not only entitles each member to all privileges usually allowed members of medical societies, but it also gives him free the journal of that body, a representative medical weekly.

The Association held its last meeting on the Pacific slope and in 1895 it will convene in Baltimore and the fifty members which live in Maryland should make it a point to prepare a warm welcome for this body and endeavor to show that the Monumental City is not only the gastronomic center of the universe, but with its many large hospitals and seven medical schools, Baltimore aspires to become a great medical center.

* * *

THE possibilities of electricity seem to be wellnigh illimitable. It has long been known that the action of the electric current on sewage causes a change and renders it harmless. The expense of the operation has always been a hindrance to its adoption.

New Methods of Sewage Disposal.

The London *Lancet* discusses very extensively two systems of sewage disposal by electricity—one the Webster and the other the Hermite Process. In the former the sewage itself is directly exposed to the current, while in the latter the sewage is changed by sea water which has been first acted on by the electrical current. In the Webster system, ordinary sewage is made to pass through channels in which fully charged electrodes are set. The sewage is thus presented to the current in a nascent state. The Hermite system was tested in the town of Worthing, England, where illness from imperfect sewerage had aroused the town council to the needs of improved methods.

Sea water contains calcium sulphate, magnesium sulphate and chloride, and sodium chloride. After electrolysis there is a slight loss of the magnesium and both oxygen and chlorine are set free. The sea water passes through a channel and comes in contact with the sewage and waste water. The report of the *Lancet* investigation committee is very long and carefully prepared and it shows that this electrolysed sea water, which has strong bleaching properties, causes the liquid parts of the sewage to become innocuous at once, while the solid parts must be exposed for a time to the fluid. The number of bacteria is reduced almost to nil and indeed cultures made with sewage which had been treated by this method were in many cases entirely sterile. This fluid may also be used for cleaning in rooms and especially in hospitals, as it is harmless and very efficacious. Each closet and place where sewage is cast out must be

supplied with Hermite fluid and if acted on by the fluid the sewage becomes sterile and harmless.

There is no statement made as to the expense of this method of sewage disposal, but it must undoubtedly be inexpensive in places where sea water can be obtained. Its adoption by a small town must be looked on as a distinct advance in the difficult problem of sewage disposal.

* * *

THE English writer never tires of bringing up the old subject of life insurance and albuminuria. Dr. G. V. Poore, in the London *Lancet*, discusses the relation of slight forms or degrees of albuminuria to life assurance and contrary to the opinions usually held in this country and even to those held in England by many, he tends to ignore slight traces of albumen, especially if future examinations show no increase or change in the amount. He says that examiners for life insurance become like practiced horse dealers and are able to "size up" a candidate and get an idea of him before examination, which is very likely true; but he adds the very heretical statement that "sometimes the candidate is unable to furnish a sample of urine at the time of examination; and if the examination has otherwise proved in all respects satisfactory we give him the benefit of the doubt and accept the life without examining the urine." Such a procedure would never be allowed by an American company of the first class.

Albuminuria and Life Insurance.

He warns against tedious and unnecessary careful examinations such as are liable to be made by the beginner, as the companies are in the business to make money and not to encourage the making of delicate tests and hair-splitting examinations. The urine should if possible be passed in the presence of the examiner, as there may be chance of fraud. This is right but it is not often done. He regrets that we have no systematic record of rejected cases.

Such subjects as this may appear hackneyed but they are continually coming up in every-day practice and with the ever-changing views on all subjects medical, this part of medicine needs constant revision. It is rather well agreed on all sides that delicate tests for albumen are not practical as our knowledge of other substances clouding in the urine is as yet too slight and too great precision in these tests might lead us to reject cases which had no albuminuria.

This paper of Dr. Poore's, while containing nothing new, furnishes food for reflection and may be read with interest.

* * *

A CONTEMPORARY calls attention to the gifts left to medicine by philanthropists and points to these as monuments showing that such benefactors are not only successful men in their professions but they are liberal. Dr. William Pepper has given from his private purse many thousands of dollars to the University of Pennsylvania; the Rev. Charles Moseley of Newburyport has given $50,000 to the Harvard Medical School and more recently Mr. William Deering, the wealthy manufacturer of Chicago, has endowed with $50,000 the N. S. Davis Professorship in the Medical Department of the Northwestern University of Chicago. There are few cities where some monument in the shape of a medical school, a hospital or a smaller endowment for the healing of disease and the prevention of pain is not in existence.

* * *

THE death of two policemen last week while in the discharge of their duty was a sad event indeed, but it may occur to many that municipal vigilance might be exercised in other directions than in chasing small boys engaged in the laudable pursuit of trying to keep cool and clean. On the contrary, the apathy and indifference of the city fathers of Baltimore, and other cities as well, in not providing public baths or setting apart places where bathing may be indulged in without restraint, is to be condemned, and the police would be much better employed in ferretting out crimes that are worth punishing and in righting misdeeds from men able to defend themselves. All such efforts will be utterly without results, for the worn and tired small boy will return to the stream at the first convenient opportunity. The poor of all large cities need care and instruction and should be taught rather than driven to do right and they should never have impressed on them by any act of the police force the idea that attempts at cleanliness constitute a misdemeanor.

* * *

The air, water and soil of the Spitzbergen Islands in the Arctic region are said to be practically free from all organisms.

MEDICAL ITEMS.

It is reported that arrangements will be made by which places for free bathing in Baltimore will be completed in a week.

Dr. A. Duval Atkinson has begun the practice of medicine with his father, Dr. I. E. Atkinson, at 605 Cathedral Street.

Dr. Henry Wickes, of Baltimore, has been commissioned as assistant surgeon in the United States Marine Hospital Service. He is stationed at New Orleans, La.

Dr. W. H. Marr, a retired physician, fell dead, last Sunday, at his home, near Upper Marlboro. The deceased came to this section from Pennsylvania about twenty years ago.

Dr. Perry Tipton, the youngest son of ex-Senator Tipton, of Nevada, died suddenly last Monday. He was twenty-four years old and a graduate of the University of Maryland.

Up to June 27, 650 physicians had registered in Baltimore at the office of the clerk of the Circuit Court. There are yet but four days before the first and all physicians should make it a point to attend to this important duty.

Dr. H. F. Getzendanner, of Frederick, Md., has been selected by the faculty of the Baltimore University Hospital, on Bond Street near Baltimore Street, to succeed as resident physician Dr. Israel J. Woodward, who recently resigned.

Miss M. A. Nutting has been appointed superintendent of nurses at Johns Hopkins Hospital, *vice* Miss Isabel A. Hampton. Miss Nutting is a graduate of the Nurses' Training School at the Johns Hopkins Hospital, and during her two years of professional service has filled the position of head nurse and assistant superintendent.

Dr. C. Theodore Williams, the senior physician to the Brompton Hospital for Consumption and Diseases of the Chest, in London, has resigned his position. He has been connected with the institution for twenty-seven years and his resignation, as well as that of Dr. Reginald Thompson, will be accepted with regret. Drs. Biss and Acland will be appointed to fill these places.

Dr. William T. Briggs, for many years editor of the *Nashville Medical Journal*, and Professor of Surgery in the Medical Department of Nashville University, died in that city on the 13th inst., aged 62 years. He had long been a prominent member of the American Medical Association, was its President at the meeting held in Nashville in 1890, and at the time of his death a member of its Judicial Council.

The Tri-State Medical Society, composed of physicians from Western Maryland, Western and Southern Pennsylvania and West Virginia, held its session at Cumberland last Thursday. At the afternoon session papers were read by Dr. J. Lee McComas, of Deer Park; Gold in Therapy, by Dr. W. F. Barclay, of Pittsburg, Pa.; and Modern and Progressive Surgery, by Dr. A. Enfield, of Bedford, Pa. At night Dr. J. Edwin Michael read a paper on Tarnier Forceps; Dr. Robert L. Randolph, on The Significance of Albuminuric Retinitis when Occurring in Pregnancy, with an Analysis of Five Cases; Cancer, by Dr. Wm. S. Halsted. After the evening sessions a sumptuous banquet was served. A large number of physicians was present. Dr. G. H. Carpenter, of Cumberland, is president and Dr. A. Enfield, of Bedford, Pa., secretary.

The following appointments are announced at the Woman's Medical College of Baltimore: Charles E. Simon, B. A., M. D., Professor of Physiology, Normal Histology and Clinical Medicine; Charles O'Donovan, B. A., M. D., Professor of Diseases of Children; B. B. Lanier, B. A., M. D., Lecturer on Pathology and Pathological Histology; Ralph Robinson, LL. B., Lecturer on Medical Jurisprudence; Ida Pollack, M. D., and Louise Eaton, M. D., Demonstrators of Obstetrics; Hugh Forsythe, M. D., S. Griffith Davis, M. D., Sue Radcliff, M. D., Jessie Brevitt, M. D., and Edith Eareckson, M. D., Clinical Assistants; Professor Simon and Dr. W. Milton Lewis, Curators. In addition to the regular clinical instruction during the next session there will be a special three months laboratory course in clinical diagnosis, the examination of urine, gastric juice, sputum, feces and blood being considered in detail. The resources of this College have been much extended of late by the acquisition of fine property on McCulloh Street. The trustees have determined to lengthen the course after the session of 1896-7. A special feature of this school is its successful medical society, which is now publishing a quarterly Bulletin.

BOOK REVIEWS.

PAIN IN ITS NEURO-PATHOLOGICAL, DIAGNOSTIC, MEDICO-LEGAL AND NEURO-THERAPEUTIC RELATIONS. By J. Leonard Corning, A. M., M. D., Consultant in Nervous Diseases to St. Francis Hospital, St. Mary's Hospital, the Hackensack Hospital, etc., etc., New York. Illustrated. Philadelphia: J. B. Lippincott Company, 1894. Pp. 328. Price $1.75.

It is rather unusual to see a whole book devoted to one symptom, pain, and yet the author has succeeded in making a very readable treatise, taking up pain from every possible standpoint. First he considers it from a diagnostic point of view, and then suggests the various means of removing and dulling pain. In this way many of the newest antipyretics and analgesics receive full attention, as well as electricity and compressed air. Surgical procedures in the treatment of pain are disposed of in one short chapter. Reflex and imaginary pains are mentioned and hypnotism is not omitted. The book concludes with chapters on the prevention of pain and of its relapses, and torture or the infliction of pain as a judicial punishment or for the purpose of extorting a confession of guilt. The book is interesting as a work of reference.

DIE BEDEUTUNG DER HYPNOTISCHEN SUGGESTION ALS HEILMITTEL, Gutachten und Heilberichte der hervorragesten wissenschaftlichen Vertreter des Hypnotismus der Gegenwart. Herausgegeben von Dr. med. J. Grossmann, Redacteur der Zeitschrift für Hypnotismus in Berlin. 11¼ Bog. in 80, Preis M. 2,50. (62 cents.) Deutsches Verlagshaus Bong & Co., Berlin W., Potsdamerstrasse 88.

This contains a large number of opinions and recommendations as to the importance of hypnotism in the treatment of disease, and is written by Dr. Grossman, who is editor of the Journal on Hypnotism, at Berlin. It should hardly be necessary to call to witness so many authorities, and yet there are so many educated persons who think that hypnotism is a species of trickery, that the author has shown in his well-written preface the importance and possibilities of hypnotic suggestion, and has added opinions from all civilized countries. He shows the enthusiasm of all specialists, and yet the most of what he says is true. His hypnotic journal would probably be appreciated by many readers in this country who have not had an opportunity of seeing it.

DISEASES OF THE SKIN. An Outline of the Principles and Practice of Dermatology. By Malcolm Morris, Surgeon to the Skin Department, St. Mary's Hospital, London, etc. With Eight Chromo-lithographs and Seventeen Woodcuts. Philadelphia: Lea Brothers & Company, 1894. Pp. xii–556. Price, $3.50.

Mr. Morris has issued a very attractive little work on the skin, which is very practical and well illustrated. The treatment is very satisfactory, even more so than in most books on this subject, and the pathology being omitted, the work is small enough to use as a hand-book and pocket reference.

REPRINTS, ETC., RECEIVED.

Report Friend's Asylum for the Insane, 1894.

The Seventh Annual Report of the Country Home for Children of Baltimore City.

Catalogue of the University of Texas for 1893-4, Medical Department, Galveston, Texas. 1894.

Fourteenth Annual Report of The Thomas Wilson Sanitarium for Children of Baltimore City, 1894.

The Fifty-first Annual Report of the Mount Hope Retreat for 1893. By Charles G. Hill, M. D., 1894.

Leprosy. By Isadore Dyer, Ph. B., M. D., New Orleans. Reprint from the *Texas Medical Journal*, 1894.

Ueber Tolpyrin und Tolysal. Von Dr. Moritz Körner in Berlin. Reprint from *Wiener Medizinischen Blätter*, 1893.

Modification du Taux de l'Urée dans l'Urine, Par le Dr. Just Championnière, Paris. Extrait du *Journal de Médecine at de Chirurgie Pratiques*.

Electricity in the Treatment of Chronic Prostatitis and Other Conditions Underlying Impotence in Men. By G. Betton Massey, M. D., Philadelphia. Reprint from the *University Medical Magazine*.

Report on the Leprosy Question in Louisiana. By Isadore Dyer, Ph. B., M. D., Dermatologist to Charity Hospital, etc., New Orleans. Reprint from the *Proceedings of the Orleans Parish Medical Society*, 1894.

A Contribution to the History of the Discovery of Modern Surgical Anesthesia, with Some New Data Relative to the Work of Dr. Crawford W. Long. By Luther B. Grandry, of Atlanta, Ga. Reprint from *Virginia Medical Monthly*, 1894.

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NOTES.

FRATNICH finds methylene blue in malaria very efficacious.

*

THERMODIN is said to be a safe, harmless and powerful antipyretic in doses from ten to fifteen grains. Its effects are slow but durable.

*

ICHTHYOL in doses of from two drops to half a drachm before meals is said to give good results in pulmonary tuberculosis. It is also used in injections in gonorrhea.

*

SPASMOTIN (spacelotoxin), the poisonous element of ergot, is insoluble in alcohol and ether. Used hypodermically in doses from one to three grains it has the same effect as ergot.

*

MULLER has used with great success salicylic acid applied to the skin, especially when there were skin symptoms with the rheumatism, and salicyl ointment was efficacious in violent pains accompanying grip. Salicylic acid may be administered with wine of creosote when there is an idiosyncrasy.

*

THIOFORM, which is bismuth dithiosalicylate, has been recommended as a substitute for iodoform. It is a light powder, insipid, inodorous, and completely insoluble in water, alcohol and ether and is useful in dressing granulating wounds and burns, as it possesses antiseptic and drying properties.

READING NOTICES.

Pruritus.—A formula which has proven signally useful in some cases is:

℞—Sodii salicylate . . 3ii
Glycerine . . . —
Listerine . . . aa 3vii. M.

*

Pinus Canadensis.—H. C. Crowell, Kansas City, in *Kansas Medical Journal*, says: In chronic ovaritis, if the cervix is found puffy, enlarged and highly sensitive, the entire infravaginal cervix may be penciled over with iodized phenol or the dark Pinus Canadensis (Kennedy's).

*

Europhen.—Subcutaneous injections of a one per cent. solution of Europhen in oil have a favorable influence in tertiary syphilis with or without the internal administration of iodide of potash, and unlike injections of the mercurials, they were found perfectly free from pain and irritation.

*

Antikamnia.—Antikamnia is now receiving attention and mention in European journals. This American antipyretic has made a name for itself throughout America in a remarkably short time, and that this popularity is due to intrinsic merit and not to advertising, is evidenced by the complimentary allusions to it in medical journals, society proceedings, and medical contributions of all kinds.

*

Sennine.—In chancroidal sores Sennine is equal to any treatment that can be resorted to. It is valuable in any and all the various antiseptic uses for which it is designed and recommended. The eligible form in which "Sennine" is presented, its non-toxic and unirritating properties, except in cases of extreme sensitiveness, when it should be mitigated with powdered starch or fuller's earth, and its real therapeutic value, must place it at the head of the long list of similar articles.

*

Celerina. — To overcome the appetite for strong drink we must employ a remedial agent which, while acting as a stimulant and tonic on the system, will cause no disgust for it or nausea when its use is continued for some time. In Celerina we have almost a certain cure. Celerina, while causing no nausea whatever through and by itself, will, in most cases, as extensive experience has proven, imbue the person using it with an actual disgust for, and an abhorrence of, all kinds of strong drink.

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ORIGINAL ARTICLES.

THE RELATION OF VARIOUS DISABILITIES TO ABNORMAL REFRACTION OF THE EYES.

READ BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 24, 1894.

By J. W. Humrichouse, M. D.,
Hagerstown, Md.

CASE 1. Compound hypermetropic astigmatism associated with frontal headache in which correction of astigmatism only was tolerated.

Miss W., 17 years old, was unable to study on account of pain over her eyes. Vision of each eye was $\frac{20}{80}$ and was made $\frac{20}{20}$ with a plus cylinder of one and three-fourths diopter, axis 15° for the right eye, and 165° for the left eye. Under atropine, vision of each eye was reduced to $\frac{20}{200}$ and was made $\frac{20}{20}$ with + two and a-half diopters spherical, combined with + one and a-half cylinder, axis 15° for the right, and 165° for the left. The correction under atropine even after one diopter had been deducted, was uncomfortable and the cylinders alone were prescribed and enabled the young lady to resume her studies.

CASE 2. Compound hypermetropic astigmatism with headache relieved by full correction.

Mrs. B., aged 23, anemic, said her eyes and head had hurt for more than a year, and that the eyes watered when she read, or looked at distant objects. Vision of right eye was $\frac{20}{30}$ and was made $\frac{20}{20}$ with a plus cylinder of three-fourths of a diopter with its axis at 90°. The left eye had normal vision and accepted no glass. After atropine, vision of each eye was reduced to $\frac{20}{200}$ and was made $\frac{20}{20}$ with + one spherical combined with + three-fourths of a diopter cylinder, with axis at 90°. The full correction was prescribed and has been worn with comfort. In hypermetropia, while giving the full cylindrical correction where astigmatism exists, I generally give the spherical correction, which is tolerated, telling the patient that the lenses must be changed to stronger upon the recurrence of symptoms of eye-strain.

CASE 3. Hypermetropia with exophoria.

Mr. R., 19 years old, had given up farm work for school. His right eye became red, watery, swollen and painful when he studied. Vision of each eye was $\frac{20}{20}$ and Jaeger 1 read from four to fourteen inches. Ophthalmoscope showed some pigment on temporal side of right disc. He had power of abduction of 8°, having fused images produced by a prism, base in, of 8°. Adduction was about 12°, a prism of 14°, base out, having always made double images. After six instillations of a 6 gr. homatropine solution vision was reduced to $\frac{20}{40}$ and was made $\frac{20}{20}$ by + 1 spherical; + .75 D. was prescribed and patient found that when he wore it for distance as well as near, the eyes were comfortable. The eyes without the correction were painful when used for distance. One would think that the lessening of the accommodation in this case would lessen also the converg-

ence, on account of the association of the two functions, and thereby increase the exophoria. Should symptoms of muscular insufficiency manifest themselves the method of Dr. George M. Gould of putting strong prisms, bases out, before each eye and fixing the gaze on an object twelve inches distant, which object is then gradually withdrawn to twenty feet, will be practiced in order to strengthen the internal recti muscles.

Case 4. Compound hypermetropic astigmatism associated with convergent strabismus in a boy seven years old which rendered him unable to study. Vision of both eyes normal and Jaeger 1 spelled from 2½ to 12 inches.

Under atropine, vision was reduced to $\frac{20}{120}$ and made $\frac{20}{20}$ with + 1 D. spherical ⊖ + .75 D. cylinder axis 90°. He has worn the full correction for three years with comfort and the squint is not now noticeable.

Case 5. Simple hypermetropic astigmatism simulating myopic astigmatism, which unfitted patient for clerical duties.

Miss C., aged 32, had vision of each eye $\frac{20}{60}$, which was made $\frac{20}{20}$ with a minus cylinder of 2.25 diopters axis at 30° for the right and at 150° for the left eye. Glasses of this kind and strength had been prescribed for her and had been worn for more than a year. After five instillations of a 4 gr. atropia solution, vision of eyes was reduced to $\frac{20}{120}$, which was not improved by the minus cylinders, but was made normal by a plus cylinder of 2.75 diopters axis 120° for the right eye and at 60° for the left. Miss C. has been wearing this correction for more than two years with satisfaction and the left eye, which was divergent, is not so at present.

Case 6. Ciliary spasm which caused myopic astigmatism.

Mrs. F., aged 38, consulted me in reference to an opacity in left cornea which had existed six months and which she feared was spreading. She complained of dread of light, of eyes watering and pain.

V. R. $\frac{20}{40}$; $\frac{20}{20}$ with —.75 cyl. axis 180°.
V. L. $\frac{20}{60}$; $\frac{20}{40}$ with —.75 cyl. axis 180°.

She was directed to take an iodine preparation, to bathe the eye with hot water, and to use an atropia collyrium. Later, upon examining the eyes while under atropia, a plus cylinder of one diopter axis 90°, gave the right eye normal vision and the left with axis at 135°, $\frac{20}{40}$ +, and were prescribed. Six months later she still preferred the minus cylinders for distance, although she liked the plus lenses for reading. She was told to wear the plus cylinders all the time, to use a weak solution of atropia and also to use a yellow oxide of mercury ointment to clear up the opacity.

These two cases, 5 and 6, show the importance of paralyzing the ciliary muscle to discover whether myopia really exists. The temptation to prescribe a minus lens, which gives normal distant vision, is great. One must not forget, however, in his dread of ciliary spasm, that myopia may exist in a hypermetropic eye, as I did for more than a year in the following case.

Case 7. Hypermetropic astigmatism in the right eye and mixed astigmatism in the left; gradual correction of astigmatism with relief of symptoms at each correction.

Miss S., 19 years old, bookkeeper, had severe headache, held her head close to book, the figures upon which became blurred.

March, 1891.

V. R. = $\frac{20}{80}$; $\frac{20}{20}$ with + 1 cyl. ax. 180°.
V. L. = $\frac{20}{200}$; $\frac{20}{60}$ with + 2.25 cyl. ax. 180°. Jaeger 2 read at 4 inches.

With this correction Miss S. was able to work with the right eye fourteen inches from her book, but could not use her left. January, 1892, patient complained again of pain, blurred vision, and of being compelled to bend over her books. With + 1.50 cylinder axis 180° before the right eye, vision became normal and discomfort ceased until March, 1893, when cylinder + 2.75 relieved her. The left eye was not used; its fundus showed a small white spot on temporal side of disc surrounded with pigment. This atrophic spot, due to circumscribed choroiditis, I thought was the cause of the poor vision. In 1894, however, when Miss S. complained of pain in the left eye only, having found no evidence of fresh inflammation, I

thought the distress might be due to faulty correction and was gratified to discover that with a — cylinder 2.25 axis vertical, combined with the + 2.25 axis horizontal, vision was made $\frac{20}{30}$, Jaeger 1 was read from 5 inches to 9, and the Baltimore Sun read easily at 14 inches.

Case 8. Myopia disabling patient for study by causing headache. Miss A., aged 14, held books close to face. Vision of each eye $\frac{20}{200}$, made $\frac{20}{80}$ by — 8 D., sph. No improvement with cylinders. Jaeger 1 read at 3½ inches. Was not allowed to use atropia. With — 7 D. she read Jaeger 2 easily at 12 inches, and was told to use this glass, provided she experienced no discomfort from it. Both discs had concentric rings of pigment, but the spaces between them were very narrow, showing that there had been only slight yielding of the retina and choroid. By removing the far point in her near work from 3½ inches to 12 inches the strain in the internal recti muscles was removed, and also the pressure on the eyeballs, thereby preventing farther bulging of the tunics at the back of the eyes. A weaker lens than — 7 D. compelled her to hold her book too near her face. She preferred — 8 D., but this was not given for fear of diminishing the size of the letters too much, and of exercising too vigorously the ciliary muscles, and also on account of the possible existence of unrelaxed ciliary spasm. With — 7 D. she has so far studied with ease.

Whether full or partial correction should be given in a case of myopia is as far as I know a question not yet decided.

Case 9. I have at present under observation a young man who has done an excessive amount of work for three years with —13 diopters for distance, and —10 diopters for the near. During this time two crescents on outer side of each disc have not increased, and his visual acuity has remained about the same, and that notwithstanding the fact that the glasses, which were furnished by an optician, were quite faulty. I have recently given him —11 D sph., ⊃, — 1 cyl., ax. 30° for the right eye, and — 11.50 D., sph., ⊃, — 1 cyl., 165° for the left, which made vision $\frac{20}{30}$ +. An additional diopter made vision $\frac{20}{20}$, but I did not give it. Two diopters were deducted from the sphericals for reading.

Case 10. In a second case of attempted full correction, a lady 42 years old with large crescents, and myopia of about 14 diopters with test lenses, and 20 diopters with ophthalmoscope, I tried successively —13, —12, —11, and got most satisfaction with —10.

Case 11. Progressive myopia improved by rest ; anisometropia with full correction.

Mr. M., aged 17, some years prior to consulting me had been given lenses of 2 and later 3 D. by Dr. J. J. Chisolm. These were satisfactory until May, 1892, when —5 D. was required to make vision of right eye $\frac{20}{20}$. About one year later, June, 1893, the vision of this eye with —5 D. was only $\frac{20}{80}$ and was raised to $\frac{20}{30}$— with —6 diopters. A crescent on lower and outer quadrant of right eye observed May, 1892, showed no increase in size nor any signs of inflammation in June, 1893. The left eye had vision $\frac{20}{80}$ with —12 D. in 1892 and also 1893. A much larger crescent existed in this eye than in the other. This eye was injured in making the correction and I put before it the same glass, a —5, which had been ordered for the right.

When Mr. M. consulted me in 1893, it was in reference to entering a technological school. I advised against it for the reasons that the myopia in the one eye he used had increased at least one diopter under my observation, and about four diopters since Dr. Chisolm first saw him, and that the eye was not comfortable when he studied. I feared it might become as myopic and useless as the other eye under the strain of severe study.

Mr. M. next consulted Dr. Webster, of New York, who advised rest from near work and who gave him the full correction of — 6 D. for the right, and the full correction of — 12 for the left eye, with instructions to wear them all the time.

In 1894, when I again examined Mr. M., I found that the unequal refraction of the eyes produced no discomfort, and that the vision of the right eye had im-

proved from $\frac{20}{30}$ in 1893 to $\frac{20}{20}$ with the same lens of 6 diopters, and that the left eye in the interval had increased its vision from $\frac{20}{80}$ to $\frac{20}{60}$ with the same lens — 12 D. The improvement I consider due to rest from near work and not to the full correction.

CASE 12. Simple myopic astigmatism with blepharitis ciliaris. Miss McC., seamstress, aged 18, was unable to sew on account of pain in head. She had vision $\frac{20}{60}$ both without and with homatropine and Jaeger 1 was read from 4 to 10 inches. Vertical lines were more distinct than horizontal. With — 2.25 cylinder axis 180° vision was made normal. Inflammation of lids disappeared, and work has been carried on with satisfaction with the glasses.

CASE 13. Compound myopic astigmatism in one eye and myopic astigmatism in the other associated with beginning failure of accommodation.

Mrs. B., 36 years old, engaged in painting and fine needle work, had vision four years ago in right eye $\frac{20}{120}$ — , which was at that time made $\frac{20}{40}$ with — 1 D. spherical ⌒ — 1 D. cylinder ax. 180°, and in left eye $\frac{20}{120}$ made $\frac{20}{40}$ by — 2 D. cylinder ax. 180°.

Mrs. B. lately has not been able to paint, sew or read with her glasses ; letters run together and her head hurts. She has had domestic troubles which have exhausted her strength. Relief in near work has been effected by putting — 1 D. spherical ⌒ + 1 D. cylinder ax. 90° before the right eye, and — 1 D. spherical ⌒ + 2 D. cylinder ax. 90° before the left.

This glass has made the patient myopic one diopter in vertical and horizontal meridians in both eyes and has renewed one diopter of accommodation in them.

CASE 14. Mixed astigmatism. Mrs. M., aged 40, had had headache continually. Distant vision of each eye $\frac{20}{200}$, and Jaeger 3 read with difficulty at six inches. With + 3 cylinder axis 90° vision was improved to $\frac{30}{60}$ and also with — 3 cylinder axis 180°. Under atropia a stronger plus cylinder 4 D. was accepted. Vertical vessels were seen without a lens and also with + 2 showing at least this amount of hypermetropia in the horizontal meridian, and the horizontal vessels with — 4 showing about this amount of myopia in the vertical meridian. On account of my own accommodation this result cannot be regarded as accurate. + 3 D. cylinder axis 90° ⌒ — 3 D. cylinder axis 180° was prescribed for distance and gave visual acuity $\frac{30}{40}$. For reading + 3 D. cylinder axis 90° was given, no correction having been made in the myopic vertical meridian, and has enabled patient to sew and read with comfort.

CASE 15. Presbyopia with hypermetropia in right eye and mixed astigmatism in the left.

Mrs. E., aged 50, could not see well at a distance and could not read.

R. V. = $\frac{20}{100}$; $\frac{20}{30}$ with + 2. 25 D sph.

L. V. = $\frac{20}{200}$; $\frac{20}{30}$ with + 4 D. cylinder, axis 90° ⌒ — 4 D. cylinder axis 180°.

Light moved in the vertical meridian of left eye in a direction opposite to the movement of a plane mirror, and in the horizontal meridian it moved with the mirror. Horizontal vessels were best seen with — 3.50 in ophthalmoscope, making the myopia in the vertical meridian about that amount, and vertical vessels with + 4 making about that amount of hypermetropia in the horizontal meridian.

With the + and — cylinders crossed as above at right angles, making a difference of 8 diopters between the two principal meridians, the visual acuity of the left eye was improved from $\frac{20}{200}$ to $\frac{20}{30}$. For reading + 2 D. was added to the distance sphero-cylindric combination of — 4 D. spherical ⌒ + 8 D. cylinder axis 90°, which made the correction for near work for the left eye — 2 D. spherical ⌒ + 8 D. cylinder axis 90°. Plus 2 D. spherical was also added to the hypermetropia correction of the right eye, making it + 4.25 D.

It has not been with the purpose of presenting anything new that these cases have been submitted to the kind attention of the Faculty, but with the hope that the general practitioner of medicine might be impressed with the importance of treating errors of refraction. He need not be a specialist in

eye diseases to treat them any more than he need be a specialist in gynecology to treat the ordinary diseases of women. It is a field of work quite as important as any in medicine and gives results quite as valuable. Surely a field which has been almost monopolized by sellers of spectacles does not present difficulties too great for the general practitioner of medicine.

A REPORT OF NINE CASES OF CONTUSIONS AND SPRAINS OF THE BACK.

READ BEFORE THE PHILADELPHIA ACADEMY OF SURGERY, MAY 7, 1894.

By Henry R. Wharton, M. D.,

Surgeon to the Presbyterian, Methodist Episcopal, and Children's Hospitals; Demonstrator of Surgery at the University of Pennsylvania.

DURING my term of service in the Presbyterian Hospital in 1892 there were admitted to the surgical wards nine patients who suffered from contusions and sprains of the back, and it has occurred to me that a short description of the method of treatment, which I have employed with the most satisfactory results in this class of injuries, might be of some interest to the Fellows of the Academy.

CASE I.—J. P., aged twenty-eight, gardener, who was admitted to the hospital May 5, 1892, received a blow upon the back in the left lumbar region from a heavy wooden tub, which caused him severe pain. An examination after admission proved that there was no injury to the spine, but there was intense pain upon pressure in the left lumbar region, and also severe pain upon motion. The patient's back was strapped with adhesive plaster, and two days afterward he was able to sit up with comfort, and he was discharged from the hospital on May 9th.

CASE II.—H. P., aged nineteen years, fireman, was admitted May 12, 1892, with the following history: While standing on the edge of the tender of a locomotive he slipped and fell between the tender and the station platform; the engine was moving at the time, and he was rolled between the tender and platform, being severely squeezed in the lumbar region.

Upon examination after admission, no fracture of the spine or pelvis could be detected, but the patient complained of intense pain in the back, was unable to stand, and suffered from retention of urine. The back was firmly strapped with adhesive plaster. Upon introducing a catheter, a large quantity of bloody urine was drawn from the bladder, and after this the patient passed the urine voluntarily, which was deeply tinged with blood for four days. The patient improved steadily, and was discharged from the hospital on May 27, being able to walk, but still having some tenderness in the lumbar region, this part being still supported by means of adhesive straps.

CASE III.—J. G., aged twenty-five years, steam fitter, was admitted on May 20, 1892. The patient stated that while boarding a moving train at Powelton Avenue he was thrown against the milk platform, striking his back and shoulder. An examination, on admission, showed slight contusion of the shoulder and marked contusion and tenderness over the lumbar region. The patient was unable to walk, and complained of severe pain upon pressure and upon making any movements. The back was strapped, which gave great relief. The patient also suffered from retention of urine, requiring the use of a catheter. The patient was discharged in good condition on June 4.

CASE IV.—D. D., aged forty-three years, bricklayer, was admitted to the hospital on May 23, 1892. The patient stated that while standing on a platform sixteen feet high, laying brick, the wall was pushed over by a derrick and he was thrown to the ground, striking upon

his back. An examination after admission showed marked contusion of back and shoulder, great tenderness upon pressure and motion, and some tenderness over the spinous process of one of the lower dorsal vertebræ. The back was strapped, which gave great comfort. The patient was kept in bed for a week, and was discharged on June 6th, in good condition.

Case V.—R. C. W., aged twenty-seven years, brakeman, was admitted to the hospital on May 28, 1892. The patient stated that he was knocked off the top of a car on which he was riding, and was thrown to the ground, striking upon his back. On examination there was marked contusion of the back in the lumbar region, tenderness upon pressure, and inability to stand or walk. The patient's back was strapped, which gave him marked relief, and he was discharged on June 30.

Case VI.—A. W., aged twenty-eight years, trucker, was admitted to the hospital on May 31, 1892. The patient stated that while moving a heavy slab or stone, it fell and struck him upon his back. An examination after admission to the hospital detected no fracture of the vertebræ, but there was great soreness and tenderness on pressure in the lumbar region. The back was strapped, and the patient was discharged from the hospital on June 3, in good condition.

Case VII.—J. C., aged nineteen years, iceman, was admitted to the hospital on June 12, 1892. The patient stated that he slipped while crossing the street, and fell, striking his back upon the curbstone. He was unable to walk, and was brought to the hospital by the patrol. Upon examination after admission it was found that the patient had great pain in the left lumbar region, but there was no evidence of fracture of the vertebræ. The back was strapped, which gave him immediate relief. This patient suffered from retention of urine, and upon evacuation of the bladder it was found that the urine was bloody. The blood disappeared from the urine in a few days. The patient did well, and was discharged on June 14.

Case VIII.—W. McN., aged thirty-five years, brakeman, was admitted June 22, 1892. The patient stated that in a freight wreck at Tacony the car on which he stood was thrown from the track, and he was thrown to the ground, striking upon his back. An examination after admission showed that he was suffering from contusion of the back and foot. The back was strapped, and the patient was discharged, in good condition, on June 25.

Case IX.—L. B., aged twenty-five years, was admitted to the hospital June 25, 1892. The patient stated that while standing on the top of a freight car he was knocked off by the Spring Garden street bridge, and was thrown to the ground, striking upon his back. On examination after admission, he was found to be suffering from severe contusion of the back, but there was no evidence of fracture of the vertebræ. The back was strapped, which gave him marked relief. The patient also passed bloody urine. The patient did well, and was discharged on June 28.

It will be noticed in the above cases that the lumbar-dorsal region of the back was the part most frequently injured, and this part seems to be that which was most commonly the seat of contusions and sprains. As regards the treatment of contusions and sprains of the back, I consider that rest in bed is a matter of the first importance, and in addition I have found that the pain and general discomfort of the patient is much diminished, and the time of treatment much shortened by having the back firmly strapped as soon as the patient came under observation. The strapping of the back is effected by taking strips of resin-adhesive or of rubber-adhesive plaster, 2½ inches in width, and long enough to extend half way around the body; these are applied so as to cover in the back, one strap slightly overlapping the other, from a point just below the junction of the last lumbar vertebræ with the sacrum to the lower ribs. These straps were often removed at the end of two or three days, and the back was re-strapped if the pain and tenderness still persisted. The straps were usually allowed to remain in place until the pa-

tient was up and about, without complaining of pain or discomfort in the region of the injury. In cases of severe contusion the straps often require renewal a number of times.

This method of treatment of contusions of the back was first called to my notice by Professor Ashhurst while serving as resident physician in his wards at the University Hospital, and since I have employed it I have entirely discarded the use of fomentations and stimulating lotions, which are generally recommended in the treatment of these injuries.

The treatment usually recommended in contusions and sprains of the back is warmth, frictions, stimulating liniments, anodynes, acupuncture, galvanism, and massage, and of these I think massage is the most valuable, employed after the acute symptoms following the injury have subsided; but in early stages of these injuries I am convinced that strapping will be found the most satisfactory method of treatment.

I have observed that the application of straps employed as above described is usually promptly followed by relief of pain, and the fixation produced allows the patient to move with more comfort, and I am very certain, after having now employed this method of treatment in a considerable number of cases, that the time required for the recovery of the injured parts is much shortened. It will be observed, by referring to the cases reported, that many of them were comparatively trivial injuries, and the patients recovered in a short time; but even in this class of cases the suffering is often very intense for the first few days. It will also be observed that Cases II, VII, and IX passed bloody urine for a few days after the injury, showing that the injury had been severe enough to produce laceration or contusion of the kidney. Lidell,[1] in his very excellent article upon contusions and sprains of the back, speaks of the frequency of hematuria in these injuries when powerful blows have been delivered upon the lumbar or dorsal region of the back. The recovery, as far as I know, in all the cases reported was satisfactory, except in Case IV. In this case the patient developed, some months after leaving the hospital, symptoms of traumatic neurasthenia, complaining of pain in the back and head, and vertigo, and brought suit against the contractor for whom he was working at the time of the injury. From what I heard of this case, and from the fact that when it was ascertained that the patient was doing his ordinary work, the suit was settled for a trivial sum, I am inclined to think that the symptoms developed were not severe, and might be classed as litigation symptoms.

In cases of severe contusion or sprain of the back when there is inability to stand or there is present great pain on motion, and where tenderness over the spine and a certain amount of fixation is present after the injury, I think there is too much tendency to attribute the symptoms resulting to an injury of the spinal cord or membrane, which injuries when unaccompanied with fractures of the vertebræ are extremely rare; whereas the injury resulting to the muscles, ligamentous structures, and nerves, with perhaps the wrenching and laceration of the vertebral articulations, is perfectly possible to account for the symptoms resulting, and I agree with Mr. Page, that many of these cases are well described by the term "traumatic lumbago."

As contusions and sprains of the back are injuries which are often followed by the development of symptoms which are described as traumatic neurosis, or traumatic neurasthenia, it seems to me that these are cases which should be carefully treated when they first come under the observation of the surgeon, for I am sure that many of these cases if so treated by rest and fixation for a short time would make more complete recoveries, and would be less likely to develop the symptoms above described. In cases of contusions or sprains of the back in which symptoms of traumatic neurasthenia develop, and which give rise to litigation, it is often difficult for the surgeon to estimate how far the original shock of the system following the injury is responsible for the symptoms presented. In

1. International Encyclopedia of Surgery, vol. iv., p. 700.

many cases the objective signs presented leave no doubt of the severe nature of the injury, while in other cases the symptoms complained of are mainly subjective in their character, and these are the cases which give rise to the most troublesome litigation. It is often difficult to decide whether the symptoms presented are merely assumed or exaggerated for fraudulent purposes, or whether, without any attempt at deception on the part of the patient, injuries trivial in themselves may be unconsciously exaggerated, and be apparently productive of serious results. Although many severe injuries of the back apparently recover without developing such symptoms as have been described, there is no doubt that the element of compensation for the suffering and disability from the injuries received play an important part in the exaggeration of these symptoms, and that expectancy may be justly credited with an important place in their exaggeration. In cases of serious disorder resulting from contusions and sprains in the back, often apparently trivial, the symptoms developing are usually progressive in their character, and soon there will become manifestly marked objective signs, such as paralysis, disturbances of the reflexes, loss of electrical excitability, disturbances of the bladder, loss of flesh, sleeplessness, etc.; which place the existence of morbid changes beyond a doubt.

CHLORAL HYDRATE—SOME OF ITS USES.

Read before the Philadelphia County Medical Society, June 13, 1894.

By Ben. H. Brodnax, M. D.,

Brodnax, Louisiana.

In conversation with physicians at various times, I have noticed they viewed chloral as merely a hypnotic, and had used it only for the purpose of relieving pain, thereby inducing sleep. I have been a little surprised at this want of knowledge of its other equally valuable properties. Early in my practice I tried to make a few medicines, combined or by themselves, do all that they would for me, and was led into experimentation with them. Chloral came in for its share, because it relieved pain, quieted the nervous system, and did not paralyze the bowels.

As a *hypnotic*, five grains of chloral combined with laudanum or with one-eighth or one-quarter grain of morphine acts splendidly, the combination intensifying the effects of each and depriving the opiate of its stimulating property. With children, by itself, in sweetened water, it has no equal; mixed with paregoric, it is also good.

I *prepare* it as follows: I just cover the amount in my case vial with glycerin —this dissolves it, and a drop about equals a grain. In this form it mixes readily with oil or water and is more quickly prepared, and more easily divided into doses, large or small. With castor oil the dose one to five grains renders it less nauseating, and does not gripe, at the same time producing quiet and rest.

Applied to the skin in eruptive disease—measles, urticaria—as follows: chloral, 10 grains (drops); carbolic acid, 10 grains (drops); water or oil, 1 to 2 ounces; almost instant relief is experienced of the intense itchings. Or chloral, 10 drops; glycerine and water, each ½ ounce, produces the same effect.

As a mouth-wash: Chloral, 10 grains; glycerine and water, each ½ ounce (a teaspoonful), produces a pleasant, cool sensation in salivation, or as a gargle. After holding it for a moment in the mouth it should be rejected and an equal amount of the fresh solution may be swallowed. Carbolic acid (10 drops) added makes it more effective in ulceration of the mucous coverings. It seems to act on the nerves locally, the same as chloroform by inhalation does on the body.

In toothache: Chloral, camphor, gly-

cerine, carbolic acid, equal quantities, applied on a small piece of cotton after cleaning the cavity will relieve pain. (Cover with more cotton to fill the cavity.) I keep the mixture, ready made, under the name of "Toothache drops," in my medicine case. If the patient has lost sleep I give a full dose of chloral by the mouth.

For ulcerated sore throat, or ulceration from any cause, such as scalds: Chloral, 10 to 15 drops (grains); water, 1 to 2 ounces, as to age; sugar, to make it palatable to children, a teaspoonful, repeated at short intervals until sleep is induced, then on waking to keep them fully under its influence. My first experience was on my only daughter, four years old. The case was so severe I feared I would lose her, and to get rest for her, gave as above, after having tried everything else I knew of. The almost immediate relief of all the bad symptoms led me to think that the medicine acted *otherwise than merely as a rest-producer.* Since then, for ten years, I have used it with the utmost satisfaction to myself and patients.

Earache: Camphor, 10 grains; chloral, 10 grains; carbolic acid, 10 grains; castor oil, ½ ounce. Drop into the ear warm. Fill the ear full, apply a piece of cotton wet in warm water to fill the external ear, then a cloth wrung out in hot water as warm as can be borne. I have seen some almost crazy children go to sleep in two or three minutes and awake free of their troubles.

As an aid to chloroform in surgery or obstetrics, 10 to 15 grains, given twenty minutes before administration of the anesthetic, seems to intensify the effect and less than one-half of it is needed to produce the desired effect. In my obstetric practice for the last fifteen years I have used it, and have observed but one case where any unpleasant effects were induced. This was in a woman with her tenth child. I gave the chloral to relax the system, 10 grains; in half an hour 5 grains more; in half an hour the chloroform. It affected her almost immediately and the child advanced and came away in good style, but the woman seemed to be dead drunk and incapable of moving herself. She slept soundly for several hours and awoke all right. She was conscious and would answer questions, but could not use herself. This was the first time she had taken either of the drugs, and she may have been susceptible—easily affected. Chloral, given before the anesthetic, seems to tide them over the excited stage of anesthesia. The first few whiffs of the anesthetic produce quiet without any excitement. I have used it in a few surgical cases with the same effect. In children a full dose of chloral, and when sleep comes on they are anesthetized in that state, and the force, often necessary otherwise, is avoided.

In coryza, where the Schneiderian membrane is very irritable, chloral, 10 grains (or drops); castor oil, ½ ounce, used with a soft mop, applied over the surface, after being dried, acts to check the excretion of mucus, and lulls the irritation and the head-pains.

The supposed influence of the drug on the heart has been urged by my friends against its use. I have not seen any unpleasant effects. In any case where there is a chance of any cardiac trouble, it is an easy matter to fortify the heart with a $\frac{1}{50}$ gr. of nitroglycerine. In one delicate woman I did this as a precaution, but even in her case I believe it was not necessary. This summarizes my experience with chloral, and when I tell you I use from five to six pounds a year, you may know that it has a very considerable scope. I never prescribe it in any quantities so as to create a "habit." In fact, I do not know of a single case of the kind.

THE "plague" which commenced at Canton the latter part of February or 1st of March, 1894, caused by drought and putrid drain effluvia, has extended through many parts of the city and country places where drains have been stagnant for lack of rain to flush them. The drought has been broken by generous rains lately and relief from the pestilence is anticipated.

SOCIETY REPORTS.

THE AMERICAN MEDICAL ASSOCIATION.

FORTY-FIFTH ANNUAL MEETING, HELD IN SAN FRANCISCO, CALIFORNIA, JUNE 5, 6, 7 AND 8, 1894.

Specially reported for the MARYLAND MEDICAL JOURNAL.

SECTION ON SURGERY AND ANATOMY.

FIRST DAY, JUNE 5.

Attending the Section on Surgery and Anatomy were some of the most eminent surgeons of America.

The opening address by the chairman, Dr. John B. Roberts, of Philadelphia, on "Some Surgical Sins," was listened to with interest, and while provoking much discussion, received general approval, except his condemnation of private hospitals, claiming as he did that they were not alone dangerous to the patient but to the surgeon, warping his judgment and permitting a too general play of selfishness. On this point he was most severely criticised in the Gynecological Section, they claiming, on the contrary, that it was only through the medium of the private hospital that the capital operations necessary in the practice of the gynecologist could be safely conducted.

Dr. Roberts called particular attention to the fact that the literature of surgery shows a general and very determined reaction against the too hasty adoption of operative measures. There is a general desire that the use of the knife shall be restricted, that a surgeon shall have an accurate pathological knowledge as well as great operative dexterity.

A great surgical sin is the overlooking of the influence of the nervous system on disease. The charging of large fees was condemned.

A man who refuses his counsel to a brother practitioner because the patient is poor commits another sin, as also does he who charges for services rendered to a physician or his family.

Secret nostrums should be denounced because usually their contents are unknown.

The remainder of the afternoon was devoted to a consideration of malignant growths.

Dr. R. A. McLean, of San Francisco, read a very interesting paper on THE NECESSITY OF EARLY INTERFERENCE IN MALIGNANT TUMORS. He said that when malignancy is once established early operative interference should be immediate to avoid recurrence. Delay is dangerous. The causes of failure may be summarized as follows :

1. Large size of growth.
2. Extensive infiltration.
3. Metastasis.
4. Ulceration.
5. Exhaustion.
6. Septicemia.

It is a great mistake to temporize and not insist upon a radical cure. The differentiation of these growths practically lies between tuberculosis, syphilis and malignancy, and one month's observation will usually confirm the diagnosis outside of microscopic examination. When the case is seen early a small operation will usually suffice. Cut wide of the growth. Remove all the infiltrated tissues and if attached to the bone remove part of it as well. If the growth is on the extremities, it is often necessary to remove the member on the proximal side of the next articulation.

Dr. John Parmenter, of Buffalo, N. Y., read an interesting paper on THE VALUE OF CAUSTICS IN MALIGNANT GROWTHS. Caustics he said, have been claimed to be followed by less frequent recurrence, to have selective action on morbid growth and to reduce the enlargement of lymphatics. These claims are not well grounded. The value of a caustic lies in the selection of proper agents and their use in selected cases. A caustic should entirely destroy the diseased tissues, and it should be rapid in its action. Caustics must always be used in conjunction with common sense. It is well to cover all the diseased tissue but do not spread the caustic beyond it. Mitigate the pain as much as possible.

Caustics may be used on growths presenting a suitable anatomical situation in which the lymphatic glands are not involved.

Caution.—Never use caustics on growths encroaching on internal organs, bone or in proximity to large blood vessels.

Dr. Duncan Bulkley, New York, read a paper on CAUSTICS IN MALIGNANT

Growth. Although caustics are used by quacks they still have their legitimate use in surgery. Caustics may be used in early stages of malignant growths, but are useless when metastatic extension has taken place. They may be used in the formative stage and in epitheliomata in accessible regions. One of the best caustics is made up of

Chloride of Arsenic,
Chloride of Zinc,
Bichloride of Mercury,

with wheat flour to form a paste. Mild caustics are useless. Nitrate of silver is of no use as a caustic. Pyrogallic acid is often serviceable after a curetting.

SECTION ON MEDICINE.

THIRD DAY, JUNE 7, 1894.

Typhoid Fever was discussed by Dr. J. E. Woodbridge, of Youngstown, Ohio.

He said that he felt sure that typhoid fever was a germ disease. He also felt equally confident that the disease could be aborted and cited many cases of undoubted typhoid which he had cut short when seen early by the energetic use of germicides, such as thymol, guaiacol, eucalyptol, etc.

Diagnosis and Treatment of Diseases of Stomach by the Stomach Tube, by Dr. A. W. Perry, San Francisco, California.

Dr. Perry stated in his paper that most disorders of the stomach depended upon fermentations, or abnormal accumulations in quantity or quality, in that organ. The fermentations were acetic, lactic, butyric, etc. Lactic acid fermentation develops normally within fifteen or twenty minutes after digestion commences, but is held in check by the hydrochloric acid of the gastric juice. Acetic and butyric fermentations are prevented by a more rapid and complete emptying of the stomach. By means of the stomach tube we can determine dilatations and we can determine the chemical composition of the stomach's contents. The stomach tube should be used only every second, third or fourth day. During the interval administration of an antifermentative is recommended. The speaker uses resorcin in five grain doses after meals, finding that it does not interfere with the digestive processes. The use of the stomach tube will prove valuable in the diagnosis of cancer and ulcer of the stomach and by allowing a quantitative test for hydrochloric acid. The author finds lavage of benefit in the treatment of the following stomach disorders, viz., acute and chronic gastric catarrh; dilatation of the stomach, not dependent upon pyloric stricture; various fermentations causing reflex symptoms; cancer; ulcer, etc.

The Law of Equivalence in Medical Science, by Dr. R. W. Murphy, San Francisco, California.

Dr. Murphy expressed the belief that before many years have passed, prophylactic measures will be discovered for such diseases as albuminuria, cancer, tuberculosis, etc., and has already been the case with small-pox, hydrophobia, etc. He called attention to the great diversity of treatment directed toward the same disease, and believed that we should have more practical text-books on the action of drugs, both as regards maximum and minimum dosage.

It was predicted that the physician of the future would be the man who closely watches the dual action of his drugs. In the case of calomel, cited as an instance, we may find physicians recommending a dosage varying from 1–20 to 60 grains for the same disease and under apparently the same conditions. The same may be said regarding almost all of the drugs in use. Among other remedial agents electricity is largely employed without thought of the law of equivalence.

The following papers were read by title:

"Champagne and Strychnine in Chest Troubles of the Aged," by Dr. G. Edw. Paxton, National City, Cal. "The Treatment of Erysipelas," by Dr. James M. Anders, Philadelphia, Pa. "The Use of Turpentine in the Treatment of Diphtheria," by Dr. E. W. Kellogg, Milwaukee, Wis. "Lung Gymnastics in the Treatment of Chronic Disease," by Dr. L. P. Walbridge, Decatur, Ill. "A Clinical Study of Scarlatina at High Altitudes," by Drs. J. N. Hall and William P. Munn, Denver, Col.

CORRESPONDENCE.

TRI-STATE MEDICAL ASSOCIATION.

CUMBERLAND, MD., *June* 28, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—The semi-annual meeting of the Tri-State Medical Association convened in the council chamber of the City Hall, Thursday, June 28, at 1.30 P. M.

This was the third meeting of the Association, the first having been held in Bedford last July, and the second here last December. The object of the Association is to bring together in a friendly and professional way the physicians of the border counties of Pennsylvania, Maryland, and West Virginia. Prominent among the originators were Drs. Henry and Enfield, of Pennsylvania, and Carpenter, of Cumberland. All the meetings have been pleasant and profitable.

Promptly at the hour named the association was called to order by Dr. Geo. H. Carpenter, the president. Quite a large number of members responded to roll call. Hon. R. T. Semner, city attorney, on behalf of Mayor Humbird, delivered the address of welcome to the visitors. Dr. S. S. Good, of Pennsylvania, responded on behalf of the visiting physicians. After reading the minutes of the last meeting thirteen new members were elected into the association. The following officers were elected for the ensuing year: President, Dr. S. S. Good, Pennsylvania; vice-presidents, Drs. J. M. Spear, Cumberland, Md., C. S. Hoffman, Keyser, West Virginia, and W. T. Henry, Pennsylvania; recording secretary, Dr. E. T. Duke, Cumberland; corresponding secretary, Dr. F. W. Fochtman, Cumberland, Md.; treasurer, Dr. W. H. McCormick, Cumberland, Md.

Dr. W. F. Barclay, of Pittsburg, Pa., read an able and scientific paper on "Gold in Therapy," which was attentively listened to by all present. Discussion of the paper followed, participated in by a number of members.

Dr. A. Enfield, of Bedford, Pa., delivered an interesting and instructive talk on "Modern and Progressive Surgery." The discussion of this paper closed the afternoon session.

In the evening, Dr. J. Edwin Michael handled the subject of "Tarnier's Forceps" in an able and attractive manner. A number of members who were unable to attend the afternoon session were present in the evening.

Dr. Robert L. Randolph, who was expected to read a paper, was unavoidably detained in Baltimore.

Dr. W. S. Halsted, of the Johns Hopkins Hospital, arrived in the evening and entertained the Association for more than an hour with a scientific and carefully prepared paper on "Cancer of the Breast." Dr. Halsted was listened to with marked attention, and was given a vote of thanks for his kindness in lecturing to the Association. Drs. Michael and Halsted were elected honorary members of the Association by unanimous consent. At the close of Dr. Halsted's address the Association adjourned.

All of the members and invited guests were entertained by the Association of Physicians and Surgeons of Cumberland, at the beautiful residence of Dr. Wm. H. McCormick. The meeting of the Association was a success in every particular, and, although young, it promises to be an important element in the development of medicine and surgery in this section of country.

E. T. DUKE, M. D.

MEDICAL PROGRESS.

THE FREQUENCY OF RENAL ALBUMINURIA.—Dr. Frederick C. Shattuck in an article read before the Association of American Physicians, on the frequency of renal albuminuria, as shown by albumen and casts, apart from Bright's disease, fever, or obvious cause of renal irritation, concludes that—

(1) Renal albuminuria, as proved by the presence of both albumen and casts, is much more common in adults quite apart from Bright's disease or any obvious source of renal irritation than is generally supposed.

(2) The frequency increases steadily and progressively with advancing age.

(3) This increase with age suggests the explanation that the albuminuria is

often an indication of senile degeneration.

(4) Though it cannot be regarded as yet as absolutely proved, it is highly probable that faint traces of albumen and hyaline and finely granular casts of small diameter are often, especially in those past fifty years of age, of little or no practical importance.

* * *

Early Diagnosis of Gastric Carcinoma.—In the *British Medical Journal*, Cohnheim of Boas's Poliklinik contends that it is possible to make a fairly certain diagnosis in the absence of a tumor. The old idea that chronic gastritis is accompanied by lactic and fatty acid formation is disputed, but in cases of carcinoma an intense reaction to Uffelmann's test for lactic acid appears. For such an intense reaction, stagnation of the gastric contents and a lasting absence of free hydrochloric acid are necessary. If only one of these conditions is present, as in chronic gastritis or dilatation of the stomach, such a reaction does not appear. The author relates a case in which a simple ulcer was suspected, and in which treatment had no lasting effect. When the stomach contents were at length examined no free hydrochloric acid was present, and Uffelmann's test gave a marked result. The stagnation of the gastric contents here was against chronic gastritis, where the food passes into the intestine within the usual time. Later, besides other symptoms, there was marked wasting, and yet no tumor could be felt. At the necropsy a limited growth was found at the pylorus. The author points out that in this case, in the absence of recognizable tumor, a correct diagnosis was made six months before death, chiefly from the constant and marked presence of lactic acid. Within eleven months, ten such cases were seen without recognizable tumor, all of which gave a positive reaction with Uffelmann's test, and yet no such reaction was ever observed in cases of gastrectasis or of chronic gastritis with absence of free hydrochloric acid. The author lays stress on the importance of early diagnosis in regard to the question of possible removal. Lastly, he refers to the new test proposed by Boas for lactic acid in the stomach contents.

* * *

The Physiological Action of Alcohol.—Dr. David Cerna, in a very exhaustive article based on laboratory experiments on the physiological action of alcohol (*Therapeutic Gazette*), draws the following conclusions as the result of his work :

1. Alcohol in small amounts excites and in large doses depresses both the peripheral motor and sensory nerves.

2. Excessive quantities cause a spiral degeneration of the axis-cylinder of nerve fibers.

3. Reflex action is at first increased and afterwards diminished by an influence exercised by the drug upon the spinal cord and nerves.

4. In small amounts the drug stimulates the cerebral functions; it afterwards, especially in large quantities, depresses and finally abolishes them.

5. Alcohol causes lack of co-ordination by depressing both the brain and the spinal cord.

6. In toxic doses alcohol produces hyperemia of both brain and spinal cord, especially of the lumbar enlargement of the latter.

7. Small doses of alcohol produce increased rapidity of the cardiac beat; large amounts, a depression of the same. In either case the effect is brought about mainly through a direct cardiac action.

8. The drug in small quantities causes a rise of the arterial pressure by a direct action upon the heart; in large amounts it depresses the arterial pressure similarly through a cardiac influence.

9. In large doses alcohol enhances coagulation of the blood; in toxic quantities it destroys the ozonizing power of this fluid, causing a separation of the hemoglobin from the corpuscles.

10. Alcohol in small doses has little or no effect on the respiratory function; in large amounts it produces a depression of both rate and depth of the respiration through a direct action on the centres in the medulla oblongata.

11. The drug kills by failure of the respiration.

12. On the elimination of carbon dioxide alcohol exercises a varying action, sometimes increasing, sometimes decreasing, such elimination.

13. The action of alcohol on the amount of oxygen absorbed also varies and may be said to be practically unknown.

14. The drug lessens the excretion of tissue-waste, both in health and disease.

15. In small amounts alcohol increases the bodily temperature; in large doses it diminishes the same. The fall of bodily temperature is due mainly to an excess of heat dissipation caused by the drug.

16. Alcohol, in sufficiently large amounts, has a decided antipyretic action.

17. In moderate amounts alcohol aids the digestive processes.

* * *

Appendicitis.—Dr. J. William White delivered an address on appendicitis before the Surgical Section of the College of Physicians and Surgeons (*Therapeutic Gazette*), the following of which is a summary:

1. The explanation of the great frequency of inflammation of the appendix is to be found in the following facts:

(*a*) It is a functionless structure of low vitality, removed from the direct fecal current; it has a scanty mesentery so attached to both cecum and ileum that it is easily stretched or twisted when they become distended; it derives its blood supply through a single vessel, the calibre of which is seriously interfered with or altogether occluded by anything which produces dragging upon the mesentery.

(*b*) In addition, there is almost always present a micro-organism—the *bacterium coli commune*—capable of great virulence when there is constriction of the appendix or lesions of its mucous coat or of its parietes.

2. The symptoms in a case of mild catarrhal appendicitis—general abdominal pain, umbilical pain, localized pain and tenderness on pressure in the right iliac fossa, vomiting, moderate fever, and slightly-increased pulse-rate—cannot at present with any certainty be distinguished from the symptoms, apparently precisely identical, which mark the onset of a case destined to be of the very gravest type.

3. It must be determined by future experience whether or not operation in every case of appendicitis, as soon as the diagnosis is made, would be attended by a lower mortality than would waiting for more definite symptoms indicating unmistakably the need of operative interference. At present such indication exists in every case if the onset is sudden and the symptoms markedly severe, and whenever in a mild case the symptoms are unrelieved at the end of forty-eight hours, or, *a fortiori*, if at that time they are growing worse.

4. It must be determined by future experience whether cases seen from the third to the sixth day, which present indications of the beginning circumscription of the disease by adhesions and which tend to the formation of localized abscesses, will do better with immediate operation with the risk of infecting the general peritoneal cavity, or with later operation when the circumscribing wall is stronger and less likely to be broken through. At present, operation is certainly indicated whenever a firm, slowly-forming, well-defined mass in the right iliac fossa is to be felt; or, on the other hand, when a sudden increase in the sharpness and the diffusion of the pain and tenderness points to perforation of the appendix or breaking down of the limiting adhesions.

5. In the beginning of general suppurative peritonitis, operation offers some hope of success. In the presence of general peritonitis with septic paresis of the intestines, operation has thus far been useless.

6. Recurrent appendicitis of mild type, like acute appendicitis, frequently results from digestive derangements. Several attacks may occur followed by entire and permanent recovery, but it is as yet impossible to differentiate these cases accurately from those which do not tend to spontaneous cure. Operation is certainly indicated whenever the attacks are very frequent.

7. Chronic relapsing appendicitis is characterized by the persistence of local

symptoms during the intervals and by more or less failure of the general health. It usually indicates operation.

8. In either the recurrent or the chronic relapsing variety operation should be advised according to the following indications formulated by Treves: whenever (1) The attacks have been very numerous. (2) The attacks are increasing in frequency and severity. (3) The last attack has been so severe as to place the patient's life in considerable danger. (4) The constant relapses have reduced the patient to the condition of a chronic invalid, and have rendered him unfit to follow any occupation. (5) Owing to the persistence of certain local symptoms during the quiescent period, there is a probability that a collection of pus exists in or about the appendix.

* * *

INTERNAL HEMORRHOIDS.—American surgery has many distinctive points and for this reason Dr. Claude A. Dundore considers in *Mathews' Medical Quarterly* the operative treatment of internal hemorrhoids, as practiced by American surgeons, and his conclusions, which are the result of a large correspondence with American surgeons, are:

1. The ligature is the safest method of operating for internal hemorrhoids, as there is less likelihood of its use being followed by hemorrhage, strictures, or ulcers.

2. The clamp and cautery causes less pain, shorter convalescence, and is less likely to be followed by retention of urine than when the ligature is used; but hemorrhage and stricture of the rectum may very often follow its improper application.

3. The practice of Whitehead's method should be limited to those cases in which the entire circumference of the anus is involved. In ordinary cases of one or more hemorrhoids *it should never be used*, as it is liable to be followed by severe after-effects, and at best could produce no more radical result than the clamp and cautery or ligature.

4. Simple dilatation of the sphincter, injection of carbolic acid, and Manley's method, are simply palliatives, and their use is very limited.

5. There is no single operation which is available in all cases. Experience alone should suggest the most efficient method of treating each individual case.

* * *

QUININE AMAUROSIS.—Dr. J. H. Claiborne, Jr. (*New York Medical Journal*) has reported a case of quinine amaurosis from which he has drawn the following conclusions:

1. Quinine in toxic doses may produce blindness.

2. The toxic dose is distinctly indeterminate.

3. The duration of the amaurosis varies largely.

4. The field of vision remains contracted.

5. Central vision usually returns to the normal.

6. There is color blindness at first; the color perception is ultimately restored within the central field.

7. The ophthalmoscopic picture is that of white atrophy.

8. Experiments on dogs show that there is atrophy of the entire optic tract.

9. The same experiments show that the cells of the cuneus are probably not affected.

10. Treatment is of no avail.

* * *

TREATMENT OF GONORRHEA.—Gonorrhea is treated in various ways, and in spite of them all rarely fails to run its course. Dr. Joseph D. Farrar reports, in the *New York Medical Journal*, his success in the treatment of this disease with the following injection:

Zinci Sulphat. . . .	gr. ii.
Potass. Permanganat. .	gr. i.
Mucilag. acaciæ	
Aquæ . . .	ää. qs. ad ℥ i.

Two drachms of this mixture are used in the ordinary conical clap syringe, and the long-nozzled pointed syringe is not advised. The bladder is not emptied until after the first injection. Two injections are made night and morning and also at noon, if convenient. He cured, in this way, eighty-seven out of one hundred and eleven cases in three to four weeks.

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See also Publishers' Department, Page 236

BALTIMORE, JULY 7, 1894.

The Treatment of Inoperable Tumors.

THE laity has always been taken with the idea of the removal of malignant tumors without the use of the knife and the profession has usually looked upon any such procedure as rank quackery, but Dr. William B. Coley reports a number of cases in the *American Journal of Medical Sciences* which were cured without the use of the knife. His method of operation is to employ repeated injections of living fluid cultures of the streptococcus erysipelatosus, thus setting up an erysipelas. The germ of this disease then "has it out" with the germ of cancer, resulting in a cure.

His cases were all of the class which could not be operated on; six of them were sarcoma and four carcinoma. The effect upon the tumors was unmistakable. In some cases there was necrobiosis and discharge, in others diminution by absorption without breaking down, and in almost every case there were signs of retrograde action. These changes were always more marked in sarcoma than in carcinoma.

It was evident from his experiments that the beneficial action was due to the toxic products secreted by the streptococcus rather than to the germ itself. As a result of experiments in the laboratory he found that the effects of the streptococcus injections were enhanced and the effects greatly intensified by also using injection cultures of the bacillus prodigiosis.

Since December, 1892, he had treated thirty-five cases, of which twenty-four were sarcoma, eight carcinoma and three either sarcoma or carcinoma. Of the eight cases of carcinoma, two were markedly improved, four slightly and two with no effect. In no case had the tumor entirely disappeared. These were all with one exception large inoperable tumors, and this exception was in a primary carcinoma about the size of a goose egg, in a woman about sixty who had heart disease and to whom an anesthetic could not be safely given. Osteo-sarcomata are the least susceptible to the erysipelas toxines. In five of the cases of sarcoma it is not unreasonable to hope for a permanent cure.

To be effective the cultures should always be from the most virulent case of erysipelas. In view of these experiments and these results there are reasons for believing malignant tumors to be of microbic origin and that the toxic products of erysipelas probably bring about such a change in the blood serum that the parasite of cancer is destroyed. This theory is the best explanation of the facts observed.

In view of the dangers of this method of treatment it is not advisable to expose the patient to a severe attack of erysipelas except in extraordinary cases. The following conclusions are drawn by the author:

1. The curative action of erysipelas upon malignant tumors is an established fact.
2. This action is more powerful in sarcoma than carcinoma.
3. This action is chiefly due to the toxines of the erysipelas streptococcus, which may be isolated and used with safety.
4. This action is greatly increased by the addition of the toxines of bacillus prodigiosus.
5. The toxines to be of value should come from virulent cultures and should be freshly prepared.
6. The results obtained from the use of toxines without danger are so nearly or quite equal to those obtained from an attack of erysipelas, that inoculation should rarely be resorted to.

THE poor often envy the wealthy, but do they always appreciate what those in better circumstances do for the poor? The heated weather is a trying time for all of every class, especially for those in the extremes of life. In large cities there are societies for the amelioration of the condition of those who by force of circumstances are compelled to stay in town. There are free excursions, there are homes provided where children and even the grown of not only the poor, but of those in even better condition, may spend two or more weeks in rest and recreation and again there are the true philanthropists, like Straus of New York, and others who provide pure milk and abundant ice for the poor at prices within reach of all. Every city provides for the shiftless and unfortunate alike and each year facilities for the improvement of the condition of the poor grow and the good done is seen if not appreciated.

* * *

THE advice to everyone in summer is to take a rest. One who works the twelve months through in reality does his work badly and he that takes a month off can do his twelve months' work in the other eleven and do it well. Men in mercantile pursuits, men in professions, men who do nothing, women, and indeed everyone, need the change. The present season in this part of the globe is the time when this change and rest should be taken. The death of a man was recently recorded in the daily press who had not taken a holiday for thirty years and yet he lived beyond middle age. The machine that is rested and taken care of and repaired when necessary is the one in the long run that will outlast all others.

* * *

WHEN a patient becomes aware that he is taking arsenic, strychnia, corrosive sublimate or some such substance, the impression is that the doctor is giving poison. It is true that almost any drug in excessive doses may cause death and as such may be considered a poison, in the sense that a poison is supposed to be any substance destructive to life or health. Some drugs, indeed some foods, will poison one person and not another. The sooner physicians disabuse the minds of the people of these erroneous definitions that smack of the dark ages the better for all classes concerned.

MEDICAL ITEMS.

Dr. G. Frank Lydston, of Chicago, is surgeon-in-chief to the new Masonic Hospital of that city.

Dr. Frank Dyer Sanger is the medical director of the Silver Cross Home for Epileptics at Port Deposit.

Dr. W. W. Potter, of Buffalo, has been reappointed on the State Board of Medical Examiners of New York.

Dr. Theophilus Parvin has been elected an honorary member of the Obstetrical and Gynecological Society of Berlin.

Dr. Isaac Ott, of Easton, Pa., has been elected Professor of Physiology in the Medico-Chirurgical College of Philadelphia.

Professor A. Weichselbaum has been elected Dean of the Medical Faculty of the University of Vienna for the academic year 1894-5.

The Society of Physicians and Nature Students which meets in Vienna next September is one of the most important medical bodies in the old world.

Dr. T. W. Clark has been physician in charge of Conrad's Sanitarium for Nervous and Mental Troubles since April 1. Dr. R. M. Dorsey is the assistant.

The trustees of the Woman's Medical College of Baltimore have decided to lengthen the course from seven to eight months, beginning with the year 1896–1897.

The Senate of the United States, on June 16, confirmed the appointment of Dr. John S. Billings to be Lieutenant-Colonel and Deputy Surgeon-General of the United States Army.

Eight hundred and nineteen physicians had registered in Baltimore City up to the morning of July 2. They still continue to apply for registration, and it is probable that all those who have a right to be entered on the books are enrolled by this time.

Dr. Emory Lanphear, for many years editor of the *Kansas City Medical Index*, has resigned the chair of Operative Surgery and Clinical Surgery in the Kansas City Medical College and has removed to St. Louis. He makes the change in order to become Professor of Surgery in the St. Louis College of Physicians and Surgeons.

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NOTES.

SALOL in large doses is liable to cause scarlatiniform erythema.

*

LIEBREICH strongly advocates the use of tricresol as an agent for disinfection for surgical and hygienic purposes.

*

PAPAIN is very useful in ulcer of the stomach; it not only relieves the pain and the dyspeptic symptoms, but it promotes the healing of the ulcer.

*

CHLORALOSE is said to be an excellent sedative in ten-grain doses, but caution is necessary in its use, as cases of poisoning from it have been reported.

*

CHLOROBROM has been much lauded as a hypnotic and sedative and is also highly recommended as a preventive and cure for seasickness. A convenient and pleasant way of taking it is in the following formula:

℞.—Chloralamid. . . . ℥iij
Potass. bromid. . . ℥iij
Alcohol. . . . . ℥j
Syr. limonis. . . . ℥ij
Aquæ q. s. ad. . . ℥vj
—M.

Dose: A dessertspoonful as directed.

READING NOTICES.

Sulfonal.—It should be borne in mind that to obtain a prompt, safe and agreeable effect from Sulfonal it should always be given in hot solution cautiously cooled to a drinkable temperature, so as to avoid precipitation. By adopting this plan not only is a smaller quantity of the drug required, but sleep occurs much more rapidly and is not followed by after-effects.

*

Chemical Food is a mixture of Phosphoric Acid and Phosphates, the value of which physicians seem to have lost sight of to some extent in the past few years. Messrs. R. A. Robinson & Co. have placed upon the market a much improved form of this compound. Its superiority consists in its uniform composition and high degree of palatability.

*

Catarrhal Affections.—An excellent cleansing and disinfecting solution for free use in the nasal cavities, by means of the spray apparatus, douche or syringe, is prepared as follows:

℞ Acidi Boracici . . . ℥i
Sodii Boras . . . . ℥i
Sodii Chloridi . . . ℥ss
Listerine . . . . . ℥ii
Aquæ Puræ . . . . ℥vi—M.

*

Salophen.—Although Salophen has been employed chiefly in rheumatic affections, especially the acute varieties, continued clinical observations have shown that it has a wide range of usefulness in nervous diseases of every kind. In the hands of a large number of careful observers it has proved an excellent sedative and analgesic in neuralgic troubles, amongst which may be mentioned sciatica, oleurodynia, intercostal neuralgia, neuritis, hemicrania and odontalgia.

*

Celerina.—In the varied conditions following the abuse of alcohol, opium and tobacco, to restore the patient and tone the nervous system, Celerina is of great value, and as a tonic to the nervous system in all these cases of nervous exhaustion, whether evolved in the cerebral or spinal centers. Celerina, in doses of a fluid drachm, three times a day, destroys the craving for alcoholic liquors. Celerina is a remedy par excellence to tone the nervous system in the varied conditions following sexual excesses and the abuse of alcohol, opium and tobacco.

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ORIGINAL ARTICLES.

NEW METHODS EMPLOYED FOR THE RELIEF OF IMPAIRED HEARING.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, MAY 23, 1894.

By Louis J. Lautenbach, M. D., Ph. D.,

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I PRESENT this short paper in order to direct attention to a comparatively new way of treating the ear, with the view of restoring or benefiting defective hearing and dissipating tinnitus.

Contrary to former beliefs, hearing is not to any great extent dependent upon the integrity of the drum-head, but rather upon the preservation of the proper relationship of the various parts of the sound-conducting apparatus. It is now known that if the external meatus be clear and the auditory nerve intact, not only may the membrane be perforated but even extensively destroyed, provided the chain of bones be normal and in perfect adaptation, the hearing will be perfect. To illustrate this, I call attention to a case I treated in 1883. In a case of long-standing suppuration with extensive granulations, I succeeded, upon the careful and complete removal of the granulations, and the subsequent subsidence of the middle ear inflammation, in retaining Shrapnell's membrane, with the chain of bones, in perfect position. The consequence was that the hearing for the voice, as well as metallic sounds, became perfect and has so remained.

Perfect hearing depends then upon the exact balance of the ossicles one to the other and to their proper relationship to the oval window and drum-head, between which they are suspended. If any or all of these parts are abnormal in any way —as, for instance, as to the weight of one or more of the bones, or if there be any abnormal attachments between the ossicles, or between the stapes and oval window, or any attachment of the drum-head to the inner wall of the middle ear —there will be derangement of that nicety of adjustment, that perfect balance which is so necessary to good hearing.

The membrana tympani may be considered as little more than the outer fixation point of the ossicles—as a protector for the middle ear, in small part, aids the hearing by concentrating all sounds and upon the short process of the malleus.

Seeing the necessity for perfect freedom of motion in this sound-conducting apparatus, we can readily understand the importance of preventing or, should such exist, removing any attachments of these bones to each other or to the surrounding parts. Any effusions upon them—effusions even if unattended by the formation of attachments—may occasion over-weighting of some one of these delicate bones, and thus interfere with the proper conductibility of sound. Should these unfortunate conditions occur, we

then have impaired hearing, and usually a greater or less degree of tinnitus.

Numerous operations and methods of treatment have been devised for these cases. They aim either to restore the parts to a normal condition, or to conduct the sound directly to the oval and round windows without the intervention of the ossicles. This latter was accomplished either by perforations or destruction of the drum-head, or the removal of one or more of the ossicles, with or without the drum-head. Since Schwarze first removed the drum-head and malleus in 1873, until the present, operations on the ossicles have become more and more frequent, until recently we find one writer reporting some 300 cases of these operations in about two years. Most operators remove the drum-head with one or more of the ossicles, but Jack removes the stapes alone without the drum-head, evidently reasoning that as ankylosis exists almost always at the juncture of the stirrup in the oval window, by thus removing the stapes the sounds will be carried directly to the membrane of the vestibule. I have performed excision with the removal of one or more of the ossicles but twenty-three times. I, however, do not think it should be resorted to until all other methods to restore mobility have failed. In future I intend to perform it only in such cases as, where after prolonged, careful treatment, especially after the thorough use of the instruments I will show you to-night, I fail to relieve distressing tinnitus or very defective hearing. I will then perform it only as a last resort, as when the ossicles are gone and there is no improvement, there is not much probability of future help.

Massage methods, or methods to break up adhesions within the middle ear, may be said to date from the time that Guyot reported the invention of the Eustachian catheter to the Paris Academy in 1724. He not only opened the Eustachian tube, thus relieving the tension of the membrane and ossicles, but forced air through it into the middle ear, thus forcing the membrane and ossicles back into their normal position, loosening or breaking any attachments that had been formed. The methods of Valsalva and Politzer were but applications of Guyot's idea, their object being the same.

It is, however, not of these methods which operate through the Eustachian tube, but of such methods as exert their beneficial action by increasing and diminishing pressure on the membrane and chain of bones, through the external meatus, to which I will call your attention to-night.

Massage methods as applied to the ear can be separated into phono-massage, the massage occasioned by sounds; pneumo-massage, that occasioned by the condensation and rarefaction of air in the meatus; pressure-massage, where direct pressure is applied to the membrane or ossicles; and mixed massage, a combination of pneumo- and phono-massage.

Probably the first method employed to produce massage was by means of the open hand so adapted to the ear as to produce a suction effect, alternately pushing and removing it with a slightly sliding motion. This method, as well as the one of opening and closing the meatus by the use of the finger, as we often see swimmers do, was undoubtedly practiced by the ancients.

Cleland, in 1771, recommended the sucking of air from the external meatus for therapeutic purposes, but it was later forgotten until Moos brought the method of rarefaction of air in the external meatus again into use as a means of treatment. A method formerly employed was by means of the suction of a syringe, with an olive-shaped tip. The tip having been adjusted to the meatus, the piston was drawn back, and, by means of the vacuum produced, the membrane was drawn outward; hemorrhage and even rupture of the membrane were often thus occasioned.

The first scientific instrument to accomplish massage, the Siegle otoscope or pneumatic ear speculum, was presented to the profession in 1864. This instrument was followed by the fungoid-shaped balloon of Lucae, and the rarefacteur and masseur of Delstanche. Siegle's otoscope consisted of an air-tight ear speculum closed without by a

glass plate, and connected with a tube to which a mouth-piece was attached. By inserting the speculum the membrane could be examined and its movability determined by suction of the mouth. By alternate suction and condensation, massage was accomplished. Lennox Browne improved the instrument by substituting a rubber bulb in place of the mouth-piece. Delstanche substituted a small double-valved air-pump, and then called it the rarefacteur. Later, Delstanche used a tube, inserted into the meatus, and produced rarefaction and condensation by means of a small hand-pump, capable of regulation, calling this the masseur; but in this instrument he omitted the speculum and thus was unable to see just what effect he was producing. Lucae about this time began to use massage directly on the short process of the malleus by means of this elastic pressure sound, alternately pressing and relieving the tension.

In 1884 Sexton used double ear tubes as a method of education of those suffering with defective hearing, apparently unconscious that he was on the threshold of an important discovery. It is of this instrument that Spear said: "It was invaluable to stimulate the auditory nerve whose functions have become impaired by disease." It remained for Currier to discover that, not only was it a good teaching method, but that the hearing often improved. These were, so far as I know, the first applications of phono-massage.

In 1887 Maloney presented the otophone to the public. This was nothing more than a speaking-tube closed at one end by a diaphragm. He used it not only as a speaking-tube, but also as a method of improving the hearing, by means of the massage it effected on the drum-head and ossicles.

In 1891 Garcey commenced to use the phonograph to improve the hearing; he was followed by Leech and Houghton. Instead of using the ordinary records, they used cylinders with lines made not by sound, but graved more or less deeply. In 1893 McFarlane used the phonograph, with the ordinary cylinders, for the same purpose.

In 1892 Garcey commenced to use a string instrument—the sounds made by the vibrations of the strings of a banjo being conducted to the ears—which he called the vibrometer. This instrument has been very much improved of late, and now consists of four strings stretched over a banjo-frame. The strings are set in vibration by a pronged wheel which, as it revolves over them, picks the strings, the sounds being carried to the ear by the ordinary double ear tubes. One string can be thus played, or two strings may be kept in vibration. In addition to this, the instrument is provided with a suction apparatus. There is a diaphragm in an air-tight cavity within the banjo-head, which is moved up and down by the motion of an eccentric on the shaft, and connected with this cavity is a pair of double ear tubes. You are supposed in this way to be able to obtain simple massage, but as a matter of fact there is a great deal of noise travelling into the ears as long as the machine is in motion.

The vibrophone is an instrument introduced last year, the purpose of which is to carry to the ear the sounds of a rapid or slow interrupter of an induction circuit, as well as to produce, at the same time, a distinct change in the air pressure on the drum-head. As originally constituted, it carried sound only, but has been modified as above at my suggestion.

Wilson has used the telephone for the production of ear massage. Semrock has used the tuning-fork for the same purpose. Hundreds of others have experimented with the tuning-fork in the same direction.

Before describing my own apparatus, I will briefly refer to the methods mentioned. The old mechanical methods of applying massage by the hand produced good effects but were crude. Cleland's and Moos's methods labor under the same disadvantage. The Siegle speculum, the rarefacteur and masseur are all of value, but they cannot be continued as long as many cases demand, nor can they be as carefully regulated as desirable. Sexton's conversation tubes are of value, as is likewise Maloney's oto-

phone, but they are conductors of sound and sound vibrations, and while they independently of this yet produce motion of the membrane and ossicles, this is not capable of exact regulation, nor is there any way of using massage without the sound. This same objection holds also so far as the vibrometer and vibrophone are concerned; neither of them gives massage without sound, although the vibrometer is supposed to answer these requirements.

It seems reasonable to suppose that in some of these cases of defective hearing associated with more or less immobility of the sound-conducting apparatus, the auditory nerve may be exhausted or diseased. We find it so in mill hands and in boiler and sheet-iron workers; their auditory nerves become at first overstimulated, and later exhausted. In treating such cases, as well as in hyperesthetic conditions of the auditory nerve, as little sound as possible should be transmitted for fear of occasioning further damage. To treat such cases I found silent or simple pneumo-massage was required. To accomplish this, I constructed a machine in which I had a slow and fast interrupter in connection with an induction coil, and connected with this was an air-tight telephone with a double ear-tube. Each make and break of the current causes a to-and-fro motion of the telephone diaphragm, and this occasions a corresponding motion of the ear drum. Later, I began to use instead of my induction coil interrupters, a metronome to make and break the current, and find it better in every respect. With it I can produce anywhere between forty and two hundred and eight to-and-fro motions of the drum membrane per minute, the amplitude of motion being dependent upon the size of the diaphragm and strength of current, both of which I can regulate. I have called this instrument the metronomic ear masseur.

For some two months I have been experimenting with the phonograph, both as an ear-test and as a remedial agent. For the former purpose I have found it the most accurate and the best test I have at my command. As a remedial agent, especially for the application of phono-massage, I have found it very valuable. For this purpose I use voice and instrumental records as well as mechanical records. By this I mean records that have been produced by cross-lining the cylinders, or regularly grooving with lines parallel to the axis of the cylinder (making the lines on some cylinders deep, on others shallow; on some close together; on others far apart).

The work with the phonograph has not progressed sufficiently far to allow me to speak as to its true scientific value. I can only say that it has, in my hands, proven to be by far the best phono-massage instrument I have employed, as sounds of any desired pitch or quality, and practically of any required volume, can be thus obtained.

To illustrate the effects of these new instruments (I refer especially to the vibrometer, vibrophone, phonograph, and the metronomic ear masseur) I will present to you but a few of the one hundred and fifty-three patients that I have treated by this method; two of these patients I have here this evening.

In order to disarm those who would contend that the improvement in hearing was in no wise connected with the massage treatment, I would say that I treated some thirteen patients by this method alone with universally good results; and out of some twenty-eight patients whom I had treated in the ordinary manner, without improvement, but on the addition of massage to the previous treatment all but three improved.

In presenting to the State Medical Society a paper on this snbject, I classified my cases into: Series I. Those who had been treated by me without improvement, and who improved upon the addition of massage treatment. Series II. Those treated by massage alone—all improved. Series III. Those treated by the combination of massage treatment with ordinary local and constitutional measures. Series IV. Deaf-mutes—two cases only, both improved. Series V. Those treated by usual measures with addition of massage without appreciable

benefit; of these there were but six in the 153 cases.

I will narrate but one case of each class.

SERIES I., Case 3.—Mr. C. Z., aged seventy-seven years, treated by me in 1884 for eight months; no marked improvement. He has been affected since 1869. He returned to me March 27, 1894; membranes very much thickened with lower half adherent to promontory; watch not heard in either ear, conversation not heard; only hears upon being talked to in ear, and then only with great difficulty. For the past year or two, unable to distinguish the piano tones; has been an expert pianist. After daily treatment for twenty days he informed his friends of his improved hearing, and remarked that for the past two days he can again enjoy the piano, being able to distinguish the tones.

SERIES II., Case 9.—Mr. J. S. S., aged sixty-five years, came March 19, 1894, with great loss of hearing and tinnitus, extending over a period of twelve years —voice hearing poor. Watch: right ear, three inches; left ear, hard contact. Two treatments a week for three weeks gave him marked improvement of voice-hearing; with watch-hearing, right and left ears, of seven and five inches respectively; tinnitus heard only occasionally.

SERIES III., Case 19.—Mrs. R. W. K., aged thirty-eight years, came March 5, 1894 (a case in which about two years previously I had given the opinion that I did not think I could improve her hearing). Both membranes had large perforations from scarlatinous otitis suppurativa thirty-seven years ago; had for years noticed a gradual diminution of hearing. Hearing for voice very poor, watch not heard, tinnitus deep in character. Treatments were given every other day. April 24 she heard a thunder-clap, a sound which she had not heard before for fifteen years. May 9 she heard a dynamite explosion (quarrying) some four miles off. May 17. Watch: right ear, eight inches; left ear, fifteen inches +; voice-hearing fair. Her friends have been so astonished at her markedly improved hearing that I have heard of this case in many quarters.

SERIES IV., Case 25.—Two cases of deaf-mutes very much improved. Miss E. G. came January 28, 1894, with history that when eighteen months old she had scarlet fever; that the ears were painful; that lymphatic glands below ears enlarged and opened; that from this time on she heard apparently nothing, but felt violent jars only; that she has endeavored to utter sounds which seemed to resemble words; that two unfavorable opinions had been given by specialists on the case. By careful treatment I arrived at the conclusion that the auditory nerve-endings were, at least to some extent, sensitive; that, however, it took a powerful sensation to excite them, and that it took a long time for a sound message to be perceived by them. For a month I used the usual treatment for such cases. On February 28 I commenced the use of phono-massage and mixed massage, and later pneumo-massage was applied twice a week, until now she can readily hear my watch tick, hears the friction cards easily, and the tuning-fork annoys her by reason of the intensity of sound. Voice-hearing is not good, but she hears a loud voice if words are slowly uttered (sluggishness of perception of auditory nerve), and she has increased her vocabulary from *nil* to several hundred words, and she is able now to converse with other children quite readily, as well as with her parents.

SERIES V., Case 27.—Miss S. B., came March 15 with history of catarrhal middle-ear disease of twelve years' standing; tinnitus has been constant for ten years; she has been treated for periods of a year or more by two Philadelphia specialists, but with no material improvement. The membranes are very much thickened and the lower portion is adherent to the promontory. Voice-hearing very poor, watch not heard, friction cards heard occasionally only. After treatments the only change has been a lessening in the frequency of the sounds; they are no longer constant. This case is one of atrophic catarrh.

I will take the liberty of calling attention to another case which illustrates that the improved hearing is not a temporary affair lasting for a few minutes or

hours, but that the change for the better is a permanent one. I refer to Case 24.

Case 24.—Miss G. R. B., aged twenty-two years, came May 3, with a history of catarrhal disease of middle ears of five years' standing. She had upon three occasions placed herself under the care of specialists in New York and Philadelphia without satisfactory results. The voice-hearing was poor, except when aided by lip reading. Watch: right ear, half-inch; left ear, hard contact. Both membranes were retracted, lustreless, and thickened; very little movement of the membranes could be observed with Siegle speculum. After usual local treatment there was no discernible effect upon the ears; after the use of pneumo-masseur for thirty minutes there was a slight increase in hearing, watch being heard—right ear, three inches; left ear, two inches. Two days later, on testing, I found her watch-hearing to be: right ear, two inches; left ear, one inch. After pneumo-treatment, this rose to: right ear, four inches; left ear, three and a half inches. Two days later on testing her, found hearing to be three and a half inches right ear, three and three-quarters inches left ear. After the treatment the hearing rose to: right ear, five inches; left ear, four inches. Two weeks later, May 14, she heard on arrival in Philadelphia, in right ear, three inches; + left ear, two and a half inches +. After treatment, right ear, four and a half inches; left ear, four inches.

It is evident, from what has been said, that massage is a method which will prove of value in the treatment of diseases of the ears, that it will in many cases obviate the necessity of severe operations, and give better results. Unlike these operations, the parts are left intact, so that should massage fail there is still an opportunity for further measures.

It may be applied by any one of four methods which, for convenience, although not strictly accurate, may be termed: 1. Pneumo-massage; 2. Pressure-massage; 3. Phono-massage; and 4. Mixed massage. The method to be employed corresponds to the case in hand; the caution to be observed is, in cases where the internal ear is affected, not to use too violent pneumo-massage, nor too shrill phono-massage, but to apply it most carefully, as otherwise there is danger of labyrinthine hemorrhage.

The time the massage is to be employed varies greatly with the variety employed, and the nature of the case in hand. Pneumo-massage can be used from two minutes in acute cases, to as much as an hour in chronic cases; and from about one minute when the shrill phono-massage is used, to fifteen minutes when the sounds are deep bass tones or are of small volume.

Of course, constitutional and other local treatments are as necessary when this method is employed as without it, although you will observe from my cases here quoted, that cases which had been treated and thoroughly treated, and yet failed to improve, improved steadily when the massage treatment was adopted. In other cases where the regular ear treatment occasioned no change, the patient was transferred to the massage treatment, and improved markedly in a few treatments.

The following conclusions are a natural inference from the work herein portrayed:

1. Poor hearing, when unconnected with closure of the meatus or disease of the nerve, is usually the result of some want of mobility in the sound-conducting apparatus.

2. This want of mobility can almost always be overcome by the use of massage, especially pneumo-massage applied directly to the membrana tympani or ossicles.

3. That the pneumo-massage in ordinary cases is the most serviceable, phono-massage being especially indicated where there is a necessity of exciting the atony of the auditory nerves caused by disuse.

4. That as the mobility of these parts increases, the hearing is restored and the tinnitus disappears.

5. That the results are most favorable in cases of hypertrophic catarrh, and in cases with retracted and perforated membranes following suppuration; less favorable in the proliferous variety of catarrh; and unfavorable in the atrophic variety

and in cases of involvement of the auditory nerve-endings.

6. That the treatment will in great part supplant the removal of the ossicles and similar operations, which operations should never be entered upon for the restoration of hearing or the removal of tinnitus until massage methods have been given a thorough trial.

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ADDRESS

DELIVERED BEFORE THE WOMAN'S MEDICAL COLLEGE OF BALTIMORE, MAY 1, 1894.

By Charles Morris Howard, Esq.,
Member of the Baltimore Bar.

GENTLEMEN AND LADIES:—I hope I shall be pardoned for first addressing what in the future is doubtless to be the weaker and more ignorant sex.

When I see this assemblage of members and friends of a well-appointed institution devoted entirely to the practice or instruction of women in the healing art, I cannot feel that the question is any longer an open one whether woman is to be allowed to come to the front. She has already come. Having once made up her mind to come to the front, she determined to do this without waiting to be allowed. And this method was perhaps the wisest and certainly the most expeditious one for her to pursue. It is a time-honored method with her, however, and female emancipation is by no means so new a thing as some of its over-zealous advocates would have us believe. One of the very first chapters in the very earliest historical book that we possess tells how a certain unemancipated ancestress of ours, possessed of an insatiate thirst for knowledge early in her career, partook of its forbidden fruit after a hasty consultation with a Serpent. And so delighted was she with the result of her botanical studies that she enrolled, as her first assistant demonstrator, that now despised creature man, without even waiting to give him his degree. However, from Genesis to Johns Hopkins is a long way to travel and, as I desire to say something about woman's impress on that and other of our notable institutions and to show up the error of the hasty and one-sided assertion that "An institution is but the lengthened shadow of a man," I must press onward.

I do not feel the necessity for speaking of woman's especial aptitude for medicine although that, as to certain branches of the profession, is obvious enough. Woman's active participation in medicine is not a segregated thing in our day. It is not a separate sortie but is part of a general movement all along the line presaging a disposition either to capture the enemy or to blow him up. The question is no longer, "What is she fit for?" but, "What can we prevent her from?"

I think that the most decisive difference between the mental attitude of this and former ages upon the woman question is that formerly a woman's fitness to prosecute a certain trade or calling was made the initial point of inquiry and hot contests raged around this point. People used to speculate vehemently as to the female incapacity to perform things it had never been allowed to attempt, whereas, nowadays, we are quite willing to admit a woman's right to do a great variety of things without in any way prejudging her ability to make a success of them. This, by the way, is the method we have been applying to men for a great many centuries. This is a scientific and experimental age and if there is any truth in the old-fashioned dogmas about woman's sphere being around her hearth, about her incapacity

for business and unfitness for original thought, these truths must hereafter make their way not as dogmas, but only if, after giving her a fair opportunity, she is weighed in the balances and really found wanting.

While by no means denying her power of reaching supremacy in the professions, I maintain that her right to pursue them is entirely independent of the question of supremacy. Her right to follow medicine, for example, does not depend upon her ability to rival Samuel Gross or Nathan R. Smith. Doubtless, few women will reach that plane, just as comparatively few men will rival the medical skill of Emily Blackwell and Mary Putnam Jacobi. Those women who cannot attain the topmost heights have a right to walk in the humbler paths of a noble profession. There is a useful place for the many people who are not supreme and the modest mission of relieving human suffering and woe, no matter how unostentatiously, is not inglorious. Female physicians are as yet so recent a departure that there has scarcely been time for many of them, according to the doctrine of chances, to achieve actual eminence. As the medical profession becomes more occupied by woman, we shall presumably hear more and more from her. I have a full belief that the spread of higher education among women and their increased participation in affairs will work during the next generation a still more astounding revolution toward their liberation and advancement than has been wrought during the last eventful half-century. I think that he would be a rash prophet who would assert that no woman will be found during the next fifty years who possesses the intellect, the industry and research to rise to the top of the medical profession. Miss Fawcett, recently at Cambridge, held her own more than successfully against the senior wrangler; Sappho used to write poetry that was by no means indifferent; Queen Elizabeth and Queen Catherine were rulers in fact as well as name. What a woman has accomplished in the past she can surely accomplish in the future under immensely more favorable conditions, and now that she is admitted into institutions of higher education and given full opportunities for scientific training, she will doubtless do her share in adding to the sum of useful human knowledge.

Here in Baltimore there are abundant evidences of woman's manifold activities in various directions. The Woman's Methodist College, woman's influence in the Johns Hopkins Medical School, the Bryn Mawr School, the Arundel Club and the Woman's Literary Club sufficiently attest that woman is now living up to all her moral and civic responsibilities, and that man alone is vile. That she has not gained admission to our Temples of Justice is due more to her apathy than to any ungallantry on the part of those who guard the Temples. Mrs. Belva Lockwood has recently been refused the right to practice law in the Courts of Virginia. I am glad that this happened in that distant and obfuscated State. Maryland, I am sure, would not make such a mistake. As a mere precautionary measure, is it not wise to let her in before she profanes the door of the Temple with a crowbar? If she some day gains admission to practice before that judge who recently rejected her, she will surely fulfill the well-established reputation of a woman scorned; and if it should happen that the distinguished judge should ever resume the practice of law at a time when she had achieved the ermine and the woolsack, the possibilities might be too awful to think about. These remarks are not thrown out by way of suggesting to obdurate judges that they need trim their sails to an immediate squall, but more in the spirit of the old woman who always used to cross herself at the mention of the devil, not knowing but that, at some distant day, it might be in his power to be of service to her.

Certainly, law and the political arena offer tempting opportunities for the ever widening scope of feminine influence. I recently attended a conference held in Philadelphia for the purpose of considering the problems of municipal government in this country. There were many distinguished men present who took part in the proceedings, but of all the

papers read one of the best, if not the best of the session, was a paper presented by Mrs. Mumford. This very clever lady proved perhaps too much, for, not satisfied with showing that woman is just as fit for government as man, she went on to demonstrate that man himself is almost totally incapable of conducting public affairs, as shown by the lamentable condition of the affairs which he conducts. Yet I think she persuaded most of her hearers that woman might advantageously be given a part in the larger domain of national housekeeping, as the Germans call it, when she has so fully established her pre-eminent skill in housekeeping of the more limited sort.

Upon one subject I feel that my duty requires from me a word of friendly caution, and that is in connection with the oft-repeated assertion that women are more liable to be quacks than are the doctors of the masculine persuasion. This is a technical branch of the medical art which I have not the special training to enable me to pass upon. But I can only say that, however strong may be the innate tendency of the sex for that tawdry professional display which the public delights to honor with handsome financial recognition, I feel sure that these native propensities have been curbed by the elevated traditions of the institution which has trained you.

I believe that only one more word of counsel will be needed by you who have mastered the problems of a difficult science. Women have now, as I said at the outset, fully attained their independence. In fact, they are rapidly gaining the ascendancy. Do not seek to enslave the other half of creation, or at least, if you enslave him, do not gall him with his newly moulded fetters. You have your choice. You may, by using your supremacy moderately and beneficently, keep him in ignorant and apathetic servitude. On the other hand, if guilty of incautious brutality, you may goad him into the necessity for a Revolt of Man such as is cleverly described in Mr. Walter Besant's novel, in which the downtrodden male half of humanity rises in a well-concerted plan for the assertion of its long forgotten rights. Woman must bear in mind, in dealing with him, that man is slow to anger, when not irritated; that he is easily managed, when not interferred with; that he has usually no objection to female physicians, outside of his antipathy to them; and finally, in the language of Sancho Panza, that "Man is as God made him—and a little bit worse."

Soils and the Cholera Vibrio.—Experiments by Dr. Dempster, reported in *The Journal*, in the laboratory of the British Institute of Preventive Medicine, on the influence of different kinds of soil on the bacilli of Asiatic cholera and of typhoid fever, lead to the following conclusions: White crystal sand, yellow sand and garden earth had no marked action on the organisms, their length of life depending chiefly upon the amount of moisture; peat, on the contrary, was very deadly to both the comma bacillus and the typhoid bacillus. The soil acted as a good filter, holding back most of the organisms, but it was possible for them to be carried through two and a half feet of porous soil by a current of water. In the discussion which followed the presentation of the results of these experiments to the London Medical and Chirurgical Society, the points of practical interest in preventive medicine that were brought out related to the value of the knowledge of a soil deadly to the bacillus—as in peat with its acid reaction; the relative rapidity with which the cholera vibrio dies in dry soil—none surviving beyond the fourth day in the dry sands or garden earth and all dying in one or two days in anhydrous soil, while in moist soils, with evaporation prevented, the bacilli were found alive on the one hundred and seventy-fourth day. On the other hand, Uffelman has shown that the typhoid bacillus could live for forty days on dry wool and for ten weeks in dry earth—a practical argument against the use of the dry closet.

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SECOND DAY, JUNE 6.

Dr. Emmet Rixford, San Francisco, began the session by reading his paper on EARLY SYMPTOMS AND DIAGNOSIS OF TUBERCULAR JOINT DISEASE. He detailed briefly the symptoms which are to be depended upon in the early recognition of the disease and its differential diagnosis.

Dr. R. H. Sayre, of New York, followed with a paper on CONSERVATIVE TREATMENT OF TUBERCULAR JOINTS. He laid much stress on the manner of applying the plaster cast in the treatment of joint disease.

TREATMENT OF TUBERCULAR JOINTS BY THE INJECTION OF IODOFORM was the title of a paper read by Dr. Stanley Stillman, of San Francisco. He dwelt upon the technique of the operation and the location of the tubercular foci.

Dr. L. C. Lane, San Francisco, after giving a general *résumé* of the various theories regarding CONCUSSION OF THE BRAIN, divided the cases into three grades, viz.: the mild, severe and fatal. The prognosis, he said, depended upon the extent of the injury. Melancholia and mania were often after-effects.

Dr. Oscar H. Allis, of Philadelphia, read a paper on the TREATMENT OF FRACTURES OF THE LOWER END OF THE HUMERUS, and found great advantages to be derived from treating such injuries with the arm in extension and the patient in the recumbent posture. It facilitates the circulation of the blood, the examination of the injured part and the dressing. Passive treatment only to be used in the latter half of the treatment.

THE CURE OF INGUINAL HERNIA IN THE MALE was the subject of an excellent paper by Dr. Henry O. Marcy, Boston, Mass.

The present interest in the surgical methods for the cure of hernia naturally gives the subject a very prominent place in the program of the Surgical Section of our National Association. It is more than twenty years since Dr. Marcy first published his methods for the cure of hernia, dependent upon a free dissection and a careful closure of the parts by buried animal sutures. He taught the practicability of reconstructing the inguinal canal so as to restore its oblique direction, and bring the intra-abdominal pressure at a right angle to it. His extended researches, publications upon the subject, and large experience have caused him to be considered an authority upon hernia, and this contribution will be read with more than ordinary interest. Space prevents a just presentation of his views, since the entire article is all too brief for the just comprehension of a subject which necessarily interests every practitioner of medicine, since by estimate there are in the United States alone between three and four millions of sufferers from hernia.

Although the obliquity of the inguinal canal was pointed out by the early anatomists, its importance from a physiological standpoint was not recognized until Dr. Marcy emphasized it as the reason why hernia was not the normal condition in the male; that to a departure from this condition, hernia usually owes its causation, and, as a consequence, the important fundamental principle upon which its cure must be dependent is the reconstruction of the inguinal canal to its obliquity and relationship.

For many reasons it would have been of great advantage to the male, if the testicle had been held in suspension within the abdominal cavity, somewhat after the general disposition of the ovary in woman. The dislocation of the testicle into an external pouch necessitates long and tortuous blood-vessels, with a corresponding increase in length of the spermatic tube, and these component parts of the cord must traverse an opening in the muscular abdominal wall, which is ever varying in functional activity and motion. We can but admire the adjustment of these entirely diverse relationships so as to render possible the

functional equilibrium of such diverse structures. In a large degree this is rendered possible only by the obliquity of the inguinal canal, which traverses the abdominal wall in a direction which is normally maintained at or near to a right angle, with the intra-abdominal pressure, a condition analogous to the penetration of the ureter through the urinary bladder, which is the only other important illustration of the principle of mechanics found in the human body. It is not a valve which acts only at the exit of the cord to prevent the reflow from backward pressure, but it is a force which is exerted upon the entire length of the canal equally, so that, when the normal conditions are maintained, the greater the intra-abdominal pressure, the more firmly in juxtaposition are the walls of the entire canal, effecting its complete closure.

Whatever may be the causes which produce a departure from this normal anatomical relationship and hernia result (usually a defective development and closure of the infundibulum process through the fascia transversalis) certain conditions invariably pertain. The first of these is an enlargement, almost always from above downward, of the internal inguinal ring. When this has taken place the thin, elastic peritoneum yields to the intra-abdominal pressure, and the fluid contents of the intestinal canal soon form a hydrostatic wedge, operating more or less constantly in its further enlargement, until at last the obliquity of the canal is lost, and only a large direct opening through the abdominal wall exists.

After discussing some of the different factors which enter into the problem of the safe treatment of the wound existing after the closure of the peritoneum, Dr. Marcy states, "The maintenance of the cord gives a wound which presents troublesome conditions and the closure of the abdominal incision in the usual way leaves the internal ring open, and the canal no longer oblique, but more or less in a direct line with the abdominal pressure. It is owing to this faulty technique, that hernia after operation, as still too commonly performed, is so likely to be recurrent, and has caused such severe criticisms indiscriminately applied to all operative measures for the cure of hernia. In order to obviate these difficulties and reconstruct the inguinal canal after its normal oblique pattern, it becomes necessary to employ some method of closure which should permit the permanent retention of the suture material in the *posterior* wall of the reconstructed canal. To fulfil this demand, it occurred to me that the structures could be united and permanently held in place by the use of buried catgut sutures, a deduction derived from the well-known but then recent experiments of Mr. Lister upon the ligation of arteries in continuity with catgut and the permanent retention of the ligature."

After a review of more recent contributions and publications upon the subject, together with a report of his own work, Dr. Marcy places in evidence the dates of his publications, which prove conclusively that to him should be given the credit of introducing to the profession buried animal sutures with the advantages to be derived from their general use in all aseptic wounds (first used by him for the purpose of effecting a cure of hernia in 1870). He also demonstrated that the operation, which has often been called after the distinguished surgeon of Padua, the Bassini operation, was in all its essentials performed by him and carefully reported before Bassini's first operation (in America in 1871-76, International Medical Congress, London, 1881).

Dr. Marcy closed with the following recapitulation of the conditions which he deems essential to the operation. "The operation for the cure of hernia must be performed with scrupulous aseptic care. The wound must be sufficiently large for free inspection. The cord is raised from its position, slight tension being made upon it upward and inward in order to expose entrance into the abdominal cavity. If the hernial tumor is large, the sac is opened and its contents replaced. The peritoneal pouch is dissected to its base, held tense, sutured at its base, resected and excised. The *posterior* wall of the inguinal canal

is intra-folded and reinforced by a line of double, continuous tender sutures, until the internal inguinal ring is closed closely from below upward about the cord. The cord is then replaced, the external structures are sutured in like manner, commencing at the upper portion of the incision and closing them closely upon the cord quite to the restoration of the external ring. The superficial tissues are brought into coaptation by light-running buried sutures and the wound is sealed without drainage. The essentials of this method are, the obliteration of the peritoneal sac, the reconstruction of the internal inguinal canal, the reinforcement of the posterior wall of the canal which restores its obliquity, the use of buried tendon sutures, aseptically applied without drainage, and the aseptic conditions maintained by the collodion seal. In a great science where there are many workers personalities count but little, but this method for the cure of hernia and the general introduction of the buried animal suture which made it possible are the results of more than twenty years of original study and investigation, and I claim the privilege of presenting them as my contribution to American surgery."

Dr. Joseph Ranschoff, of Cincinnati, emphasized the great importance of operative interference in strangulated hernia and the great danger to be apprehended from prolonged taxis which had a tendency to decrease the vitality of the bowel as well as to make the subsequent operative procedure less favorable in its results.

Regarding the radical cure of inguinal hernia, Dr. A. E. Rockly, of Oregon, advocated the idea of operative interference both in cases of long standing and where the hernia is very large.

Dr. H. O. Marcy, of Boston, who is the author of the Marcy operation for the radical cure of hernia, advised the use of kangaroo tendon instead of catgut sutures in the closing of the inguinal opening.

Dr. C. F. Buckley, of San Francisco, read a paper on the SYMPTOMS AND TREATMENT OF TUMORS OF THE BLADDER, consisting mainly of a detailed account of three cases of tumors of the bladder produced in these patients undoubtedly by traumatism of the peritoneum.

ANTIFERMENTATIVE SURGERY was the subject of a paper by Dr. Hogan, of Texas.

Dr. C. F. Buckley exhibited two interesting specimens. One a slate pencil removed from the bladder of a male by the median operation. The other specimen was a collection of gall stones removed from the gall bladder of a patient during life.

Dr. Powell, of Marysville, California, read an instructive paper on the PATHOLOGY AND SYMPTOMATOLOGY OF HEMORRHOIDS, ANAL FISTULA AND ANAL FISSURE. Clinically he divided piles into external and internal, although their pathology is the same. The veins involved are the inferior and superior hemorrhoidal plexus. In their initial stage they are nothing more than dilated rectal veins. The causes he enumerated were fecal accumulations, the gravid uterus or some obstruction to the hepatic circulation. The internal piles he classified into: 1. venous; 2. arteriovenous; and 3. the capillary. The speaker next took up the subject of anal fistula. This usually originates in an ulcer. It may also be caused by a thrombus or tubercular foci which induces suppuration; this trouble he said was often not accompanied by any urgent symptoms.

The subject of anal fissure was next discussed. This the speaker said was a most important subject, practically not because of its pathology, but rather because of the pain and annoyance, which invariably accompanies it. Among the characteristic symptoms mentioned: Dull aching pain aggravated by evacuation of the bowels, morning diarrhea, loss of blood, continual irritation of the genito-urinary organs and tender prostate.

Dr. G. B. Somers, of San Francisco, read a paper on the TREATMENT OF ANAL FISTULA. The treatment he said was by no means always a simple one on account of two complications. 1. Cicatricial tissue frequently found in the canal, and 2. That collateral sinuses often existed, hindering the surgeon in

his work. In most cases the fistula is preceded by an abscess, which may be either pyogenic or tubercular in origin. Methods of treatment are mainly four: 1. By injection. 2. By ligation. 3. By Mathews' fistulatome; and 4. The radical operation by the knife. Dilatation of the sphincter, he said, should always precede the operation.

Dr. Thomas W. Huntington, of Sacramento, read a paper on the TREATMENT OF ANAL FISSURE. The speaker stated that anal fissure, though more common between the ages of 20 and 35, occurs at times during infantile life and in old age. It occurs as often in men as it does in women, a view not generally held up to this time.

The symptoms are morning diarrhea, tenesmus, intense paroxysmal paralyzing pain quite out of proportion to the size of the ulcer.

There are two general methods of cure: 1. By dilatation of the sphincter; and 2. By incision. Incision is always to be done under anesthesia. The speaker favored the combined plan of incision and dilatation.

A paper was read by *Dr. Rosenstirn* on the subject of the TREATMENT OF STRICTURE OF THE URETHRA. He gave his experience with the employment of gradual dilatation and internal urethrotomy. He decidedly favored dilatation, and that in his opinion internal urethrotomy will eventually be abandoned because of the dangers associated with the operation, and because, in his opinion, the cure after urethrotomy was not any more permanent than after gradual dilatation.

Dr. Thomas, of Pennsylvania, said that in certain cases he decidedly favored internal urethrotomy, in others divulsion.

Dr. Huntington remarked that he rather favored internal urethrotomy, as gradual dilatation did not always cure the discharge.

Dr. Dodge, of Michigan, said he had seen worse reaction from the use of the sound than from internal urethrotomy.

A number of other physicians favored internal urethrotomy in many cases, and said that the operation will always occupy a place in surgery.

MEDICAL PROGRESS.

TETANUS TREATED WITH ANTITOXIC SERUM.—Giusti and Bonaiuti (*British Medical Journal*) describe a case of tetanus treated with antitoxic serum. The case is remarkable, on account of its clinical course, its successful issue, and the amount and power of antitoxin used. The patient, a robust man, received severe lacerated wounds on the face, one of these being deep and dividing the zygomatic process, in a railroad accident. All the wounds were freely contaminated by earth, and the patient's leg was also the seat of a simple fracture. Notwithstanding prompt and careful cleansing with antiseptics, etc., some trismus and exalted sensibility made their appearance on the day after the occurrence, leading the observers to suspect the onset of tetanus. Nevertheless, the trouble disappeared, and the patient did well until January 7—twenty-one days after the accident. Undoubted tetanus then made its appearance, characterized by great respiratory and cardiac difficulties and obstinate vomiting, in addition to the more usual symptoms of a severe case. After three days of unavailing application of the ordinary treatment—chloral, calomel, vapor baths, etc.—a consultation was held with Tizzoni, who at once instituted the treatment with antitoxic serum from a highly immunised horse (antitoxic equivalent 1: 10,000,000). On February 1 two injections of this serum (40 and 20 c. c.) were given. After these the patient experienced a period of calm, and got a little sleep. Next day, temperature being high and tetanic symptoms still prominent, two injections (20 and 10 c.c.) of serum from an immunised dog were given (relative power 1 : 10,000,000). The tetanic symptoms then disappeared for a time, to reappear, however, in a very mild form during the night. On February 3 an injection of dog's serum (10 c.c.) was given in the morning, and in the evening 50 centigrammes of alcohol precipitate of the horse serum, dissolved in water. On February 4 to 8 further injections of dried precipitate or of dog's serum were made, although the

non-appearance of further tetanic symptoms probably rendered some of these superfluous. From this time the patient's condition improved steadily. He was at last discharged cured. The total amounts of protective material used were: horse serum, 60 c.c.; dog serum, 110 c.c.; dried alcoholic ppt. of immunised horse serum, 2 grammes, equivalent to about 20 c.c. of serum. Attention is drawn first to the early symptoms, appearing on the day after the accident, and due probably to absorption of a dose of ready-formed toxin from the contaminating earth; secondly, to the occurrence of a severe attack of "cephalic" tetanus after the long incubation period of twenty days; thirdly, to the complete failure of ordinary measures, and the rapid success of the specific treatment; lastly, it was suggested that the dog's serum had probably a more potent effect than the other variety in reducing temperature. The dried precipitate of serum was somewhat difficult to use, on account of its imperfect solubility, and the risk of contamination during the process of dissolving it.

* * *

The Influence of Sugar and Tobacco on Muscular Effort.—In 1892 an important series of experiments were undertaken by Dr. Warren Lombard upon the influence of tobacco on muscular effort. The same subject has been investigated by Dr. Vaughan Harley, and the results of his observations are recorded in the first part of the *Journal of Physiology* for the present year. Dr. Vaughan Harley agrees with Dr. Lombard in considering that the amount of work done by the same set of muscles at different times of the day undergoes periodical variation, so we may accept as a fact that there is a diurnal rise and fall in the power of doing voluntary muscular work, in the same way as there is a diurnal rise and fall in bodily temperature and pulse. It is remarkable, however, says *The Lancet*, that, instead of the greatest amount of work being done, as might have been expected, on rising in the morning after a good night's rest, it is found that at 9 A. M. the smallest amount of work is accomplished, the powers of doing muscular work in Dr. Harley's case increasing each hour up to 11 A. M. Immediately after lunch there is a marked rise, followed an hour later by a fall, whilst again an hour later, or about 3 P. M., the amount of work accomplished reaches its maximum. Then, from some unexplained cause, there is a notable fall at 4 P. M., which is succeeded by a rise at 5 P. M., after which a progressive fall takes place during each successive hour until dinner. Even during a prolonged fast more work was capable of being executed from 11.30 A. M. to 4.30 P. M., than at 9 A. M. Dr. Harley admits, however, that further experiments are required to determine this point satisfactorily. It was found in his experiments on the muscles of the middle finger that in corroboration of a well-known physiological fact regular exercise caused increase in the size of the muscles brought into play and at the same time up to a certain point rendered them capable of performing more work. Sugar, taken internally, proved to be a muscular food, since, when taken on an empty stomach, there was on that day an increase of 25.6 per cent. in the work done by the left middle finger, while the right middle finger showed an increase of no less than 32.6 per cent. Dr. Harley varied the experiment of administering sugar in many different ways, but always with the same result. The vigor of the muscles was always augmented. The influence of tobacco was not so marked in Dr. Harley's experiments as in those of Dr. Lombard. Dr. Harley considers that moderate smoking in one accustomed to it neither increases the amount of work nor retards the approach of fatigue. It perhaps slightly diminishes muscular power and hastens the onset of fatigue. Dr. Lombard holds that the use of tobacco has a powerful influence in this direction.

Such experiments as these, even when no absolutely definite result is arrived at, are of importance, and if carried out with due precautions against error in a large number of men would undoubtedly constitute the most satisfactory basis on which a sound system of training should be carried out.

Hematoma of the Dura Mater and Scurvy in Children.—In the last number of *Brain* Dr. George A. Sutherland has an interesting paper, an abstract of which appears in *The* (London) *Lancet*, in which he relates at length the clinical history and the post-mortem appearances of two cases, in which, associated with rickets, there were also present definite manifestations of scurvy, and amongst those the rare condition, in this disease, of hematoma of the dura mater, or pachymeningitis hemorrhagica. The first case was that of a female child aged two, who had been fed on the breast for the first four months, and after that time almost entirely on a milk food. A month before admission there had been great pain in the right thigh, and two days before she came under observation a swelling had manifested itself on the right thigh and also on the left upper arm. There had likewise appeared a bruise-like discoloration on the right side of the forehead. On admission a smooth, firm, tender swelling was found on the left upper arm, and the right femur was found to be fractured about the centre. Two days later signs of cerebral involvement were present. There were sickness, rigidity of the neck, and rigid flexion of the arms, and the head and eyes were directed to the left side. The child gradually sank, and died on the same day. At the necropsy an extravasation of blood was found over the vertex of the brain, under the dura mater, while the structures at the base were covered with a thick yellowish membrane which contained no tubercles or nodules. This extended to the Sylvian fissure on each side. The frontal region of the brain also contained two hemorrhagic cavities, one on each side, and on microscopic examination the basilar artery was found to be occupied by a more or less organized thrombus. The right femur was broken across, and under the periosteum was a mass of material, for the most part soft and unorganized, but having in parts a cartilaginous consistence. A similar fracture was present in the humerus. The liver was tough and small, and the other organs seemed normal. The second patient was also a female, aged fourteen months, who was admitted on February 10 (the year is not given), and who had been first seen in the previous November. She had had a fit and was subject to bronchitis. Over the right parietal and occipital region was a soft fluctuating swelling, and there were two subcutaneous hemorrhages on the back and another on the inner surface of the right arm. There was also some ulceration around the teeth. On March 7 there was an eruption of hemorrhagic spots on the abdomen and back. Previously to this there had been a syncopal attack and another followed on March 9. After this the child lay in a state of torpor, and finally succumbed on March 26. At the necropsy a subconjunctival hemorrhage was found in the right eye, and the remains of a hematoma were found in the parietal region, corresponding to the large fluctuating swelling described during life. In this situation, also under the dura mater, was found a dense, fleshy, purplish-red deposit which covered the surface of the brain. This was loosely attached to the dura mater and consisted of three layers, the most inferior being adherent to the pia mater. The brain was atrophied, and weighed only fifteen ounces. In the spinal canal, also, was a deposit of soft material underneath the dura mater, and, covering the cord, apparently an effusion of blood-stained lymph. The microscope showed the false membranes on the brain to consist of blood-clot in different stages of organization. The cases, it will be seen, are of unusual character and of considerable interest, and the second especially Dr. C. Sutherland regards as supporting the theory of the non-inflammatory origin of pachymeningitis hemorrhagica.

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Intra-Venous Saline Injections.—The *Philadelphia Polyclinic* quotes Dr. C. T. Parker, who reports that at the Chambers Street Hospital, New York, this method of treatment is used on all subjects of uremic coma, and found to answer better than any other. If the patient is plethoric, it is supplemented by the taking of blood from the other arm, one or two quarts of the saline solution being used.

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THE changes which have taken place in the treatment of the insane in the past four years are very marked. Formerly the insane were simply confined to wards or rooms, and if violent were most inhumanly treated, but no attempt at the cure or amelioration of their condition was ever made.

Modern Treatment of the Insane.

In more recent years mental derangement is regarded as brain sickness and the prison or asylum idea has been relegated to oblivion.

Dr. W. P. Manton, of Detroit, in the *Medical News*, maintains that the insane and even the hopelessly demented have as much right to relief from all bodily ailments as the mentally sound; and with particular reference to diseases peculiar to women, it is certain that insane women are as susceptible, in most instances, of suffering from acute disorders as the sane and that these conditions often exert a greater or less influence on their mental condition.

Experience in large asylums has shown that many insane women can be permanently cured by the proper surgical operation. This does not necessarily mean the indiscriminate castration of women, but the operation on carefully selected cases.

In summing up his conclusions on these cases Dr. Manton says, 1. That insane women have both a moral and a legal right to amelioration from suffering dependent upon local disorders, without reference to the effect that such relief may have upon their mental condition—that is, as regards cure.

2. That indiscriminate operating upon the insane, especially the removal of the normal appendages for the so-called cure of insanity, is not only to be deprecated on account of its utter uselessness, but also denounced because of the unnecessary mutilation of the patient.

* * *

THE recent advances made in the study of tuberculosis have led investigators to find traces of it in organs where it was formerly not supposed to exist. This is instanced in chronic urethral discharges which in some cases are found to be of tuberculous origin. Every physician has had the experience of treating an old gleety discharge which refused to be cured in spite of every kind of therapeutics.

Persistent Urethral Discharges.

Dr. Eugene Fuller reports in the *Journal of Cutaneous and Genito-Urinary Diseases* a series of twenty-two cases in which he found chronic discharge from the urethra with inflammation of the seminal vesicles, which inflammation was found to be tuberculous in character. He warns against careless rectal digital examination lest more harm than good be done. He draws the following conclusions from his cases:

1. Seminal vesiculitis is the cause of chronic urethral discharges in a certain percentage of cases.

2. In about one-third of these cases the seminal vesiculitis is tubercular in character.

3. It is most important to differentiate between the simple inflammatory and the tubercular cases, owing to the difference in prognosis and treatment.

4. In the simple inflammatory cases the prognosis is good unless the subject is of an advanced age, the duration of the treatment depending largely on the chronicity of the case.

5. The treatment employed in these simple cases consists of stripping the vesicles, there-

by squeezing out into the urethra their inflammatory contents by means of the fore-finger introduced into the rectum. This treatment should be employed once in five to seven days, a long interval being allowed to elapse between treatments should signs of acute inflammation appear as a result of the manipulations.

6. The duration of the treatment may be all the way from a month or six weeks in subacute cases to many months and possibly a year in very chronic ones.

7. At the commencement of treatment the parts are usually very tender, indurated and distended. If the case progresses favorably all these elements gradually diminish and finally disappear as resolution takes place. The discharge customarily wholly disappears before a cure in the vesicles is attained.

8. In tubercular cases the tenderness in connection with the vesicles is not liable to be so great as, and the induration more than, in simple inflammations. In this form of inflammation the parts resent the manipulations, unless, indeed, they be most gentle, and even then it is a question if this form of treatment is beneficial. If the tubercular condition is not diagnosed at first the manner in which the vesicles, when so involved, resent the ordinary manipulations by becoming more tender and indurated, thus aggravating the urethral symptoms, speedily renders the correct diagnosis apparent.

9. Many of these tubercular cases become quiescent under internal medication and hygienic measures.

* * *

It is gratifying to note that as the result of the exertions of several public spirited physicians and other citizens, the City Council of Baltimore has voted an appropriation of five hundred dollars for free baths for the poor. This action is tardy but it comes at a time when the warm weather emphasizes its necessity. With good advice and care this small sum may do a great deal of good. It would be well if the keeper of each bathing place were instructed in the methods of resuscitation of persons supposed to be drowned, for accidents due to long submersion will surely occur and help will be needed promptly.

* * *

The favorite occupation of many persons in warm weather is drinking, under the false impression that it will make them cooler. With few exceptions anything that contains alcohol is sure to make one warmer and the depressing effects of an alcoholic added to the outpouring of perspiration should exclude every form of alcohol as a cooling beverage in summer. Not much better are the various so-called sweet soft drinks that so often upset the stomach and pervert what little appetite one has.

* * *

Much of the danger from contagious diseases in any country lies in the concealment of the first cases with the false idea that the public will become unnecessarily alarmed and trade will be injured. This is a grave mistake. Just now foreign reports are denying the presence of Asiatic cholera in Germany and other places. As this is the season of cholera morbus and other diarrheal disease, it may be very natural that mistakes are made, and that the alarmists will report dangerous cases as innocent cases, but our means of diagnosing many diseases are so complete and perfect that there should be no doubt, and when a cholera case has actually appeared it should be isolated and reported. This will inspire public confidence and when the existence of such disease is denied the report will be believed.

* * *

Medical journals are usually published as mirrors of thought and medical opinion of the country or State whence they emanate, and they should by all means be free from bickering and back-biting, and yet hardly a week passes but some are finding fault and looking for each other's weak points. This is not only unnecessary but it is extremely distasteful to most readers, who are not seeking for gossip or private grievances in a scientific journal, but read that they may be benefited and instructed. It is only the poorer papers of a certain class that get their support by printing slanders against their neighbors, and all such personalities should be omitted from the columns of respectable medical journals.

* * *

That filth and disease go hand in hand is shown by the outbreak in Canton, China, of that disease known as the black plague or black death. One steamer has arrived from China in this country since this disease has been reported, and one of the crew died of the disease before landing. A careful inspection of all incoming and outgoing Chinese steamers will be made.

MEDICAL ITEMS.

Prussia is still opposed to cremation.

Boston is having trouble with the disposal of the house waste.

The American Physicians' Sanitarium Association has surrendered its charter and has been dissolved.

The first dispensary for the free treatment of the poor is said to have been founded in London in 1696.

Small-pox still continues to flourish in some parts of the country. There are cases still reported from Connecticut.

Prof. T. R. Fraser, of Edinburgh, has been awarded a medal by the Royal Society of Edinburgh for his work on strophanthus.

Dr. Charles Wattenscheidt has removed his office and residence from 1514 Lafayette Avenue to southwest corner Fulton and Lafayette Avenues.

The Medical Society of the State of West Virginia held its twenty-seventh annual meeting at Berkeley Springs on the 10th, 11th and 12th of July.

A medical party has been formed by physicians in the French Senate and Chamber and the duty of the party is to watch professional interests in the two houses.

Dr. John T. Dawkins, one of the most prominent physicians of Calvert county, Md., died suddenly last week at his home near Port Republic. Dr. Dawkins was about sixty years old and a graduate of the University of Maryland in 1858.

The fourth annual meeting of the American Electro-Therapeutic Association will be held in New York, September 25, 26 and 27, at the New York Academy of Medicine. Members of the medical profession are cordially invited to attend. William J. Herdman, M. D., president; Margaret A. Cleaves, M. D., secretary.

Dr. John M. Byron, the bacteriologist connected with the Loomis Laboratory, at New York, and who was in charge of Swinburne Island Hospital during the cholera invasion of 1893 and again in 1894, has sailed for Genoa, Italy. He will spend the summer in that country, with special instructions to investigate any reports of cholera in Italy or adjacent countries, and keep the health officers of this port fully informed concerning the disease.

The death of Dr. P. Glennan, of Washington, which occurred on Sunday, June 17, is noteworthy among other reasons as being that of the last surgeon of United States volunteers to be mustered out of the service and for twenty-six years the executive officer of the Freedman's Hospital. Dr. Glennan was born in the State of New York in 1826. He was the father of Dr. J. D. Glennan, of the army, and of Dr. A. H. Glennan, of the Marine Hospital Service.

The American Public Health Association will hold its twenty-second annual meeting at Montreal, Canada, September 25, 26, 27 and 28, 1894. The following subjects will be discussed: The Pollution of Water Supplies; The Disposal of Garbage and Refuse; Animal Diseases and Animal Food; The Nomenclature of Diseases and Forms of Statistics; Protective Inoculations in Infectious Diseases; National Health Legislation; The Cause and Prevention of Diphtheria; Causes and Prevention of Infant Mortality; The Restriction and Prevention of Tuberculosis; Car Sanitation; The Prevention of the Spread of Yellow-Fever; On the Education of the Young in the Principles of Hygiene; Private Destruction of Household Garbage and Refuse; Disinfection of Dwellings after Infectious Diseases; Inspection of School Children with reference to the Eyesight.

The Directory managed by the Nurses' Association of Baltimore will not be started until fall. For the present the following nurses can be found at these places: Mrs. E. Van Santvoort, 409 St. Paul St.; Miss S. S. Ravenel, 409 St. Paul St.; Miss May Williams, 409 St. Paul St.; Miss M. E. Bradbury, 25 W. Preston St.; Miss Emma Daly, University Hospital; Miss Lucy E. Tally, 1117 Harlem Ave.; Miss Anna E. Lee, 1336 N. Caroline St.; Miss E. Mayes, 807 Druid Hill Ave.; Miss M. A. Pyatt, 24 N. Howard St.; Miss Lizzie Shertzer, University Hospital; Miss Anna M. Schoir, 27 N. Carey St.; Miss Clara Mergardt, 1003 W. Baltimore St.; Miss Anna Schleunes, Hillsboro, N. C.; Miss E. D. Teas, 622 W. Lombard St.; Miss M. E. Cornman, 1448 Rhode Island Ave., Washington, D. C.; Miss Alice Young, 1122 12th St., N. W., Washington, D. C.

CURRENT EDITORIAL COMMENT.

[*The Medical Brief.*]

IN the medical profession individual responsibility is greater than in any other vocation. Success is the fruit of the doctor's own ability and address. Let him free his mind from prejudices, traditions, conventionalities, and enter the medical field with a determination to judge the wheat and the chaff, and do his own winnowing.

[*American Medico-Surgical Bulletin.*]

CONSISTENCY is a great virtue. If the physician advises his patients to give nothing but sterilized milk to the baby, let him see to it that *his* baby gets sterilized milk only. If he recommends all drinking water used in the family to be boiled, let him insist that *his* family shall drink no water unless boiled. If he is convinced that the use of double beds is unsanitary, let him demonstrate it to himself and his neighbors by procuring single beds in his own household.

[*The Medical and Surgical Reporter.*]

THE responsibility of the editor of a medical journal is very great. It is his duty to promote the diffusion of medical knowledge, not only by his own writing, but by seeking from contributors articles that will be useful to this end, and by selecting from contemporary publications the most valuable papers, of which usually only abstracts are presented. The medical journal is a most important means of professional aid and education. It ought to help the practitioner in his daily work, and it ought to enlarge the sphere of his knowledge, and stimulate him to active thought.

[*The Kansas Medical Journal.*]

THERE is hardly a village in the West which has not its laparotomist. Not that the village surgeon is less competent than his metropolitan brother to do the operation, but extensive experience and a thorough knowledge of the pathological conditions which demand operative procedure can only be obtained after years of observation and constant investigation where such material is abundant. It is readily acknowledged by some of our best abdominal surgeons that had they known in the beginning of their work what they have learned by long experience, appendages might have been saved that were sacrificed through misinterpretation of symptoms, and lives that were lost by operative interference might have been saved by more conservative means.

[*Buffalo Medical and Surgical Journal.*]

IT would be a great pity to have the annual appropriation for the library of the Surgeon General's office reduced by $3,000, which is proposed by the present appropriation committee of the House of Representatives. It has become pretty well known that the present Congress, feeling itself unable to cope with large questions, has turned to the consideration of petty details, upon which it is wasting much valuable time. But it is beyond the comprehension of even the best friends of this body that it should propose to do so contemptible a thing as to curtail the valuable educational work of the Surgeon General's office.

[*The National Medical Review.*]

WE have often remarked that fee bills are not a necessity to any body of medical men. A physician should be allowed to charge what he thinks his services are worth. If he rates them too high his patrons will soon find it out; while if he puts them too low he alone will be the loser. However, the courts of the State of Kansas have recently decided that if a physician, who is a member of any association having a fee bill, should sue for services he would not only lose his bill but would also be liable to fine or imprisonment, or both. The courts have construed this "fee bill" to be in the nature of a trust or combination, and as such is illegal.

[*Maritime Medical News.*]

THE fact that the members of the medical profession have always been ready to give a large amount of their time and skill in charity is well known, is worthy of more recognition than it gets, and redounds to their credit without in any way impugning their judgment. It is also well known that the profession have at all times been ready to give their advice to the State in matters pertaining to public health, to the prevention of disease and to the sanitary welfare of the public without reward or expectation of any. This, too, is worthy of more recognition than it gets, redounds to the credit of the profession, but *not* we think to their good judgment. What is cheaply obtained is, as a rule, little prized, and if the State, when it wants the best medical advice on any question of public health, should pursue the same course it does when it requires legal advice on any question, we think both it and the public for whom it acts would be better served, and the information obtained more highly valued, and probably more frequently acted upon.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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TO PRACTITIONERS OF MEDICINE.

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NOTES.

IZAL is another highly recommended antiseptic, which was first mentioned in Russia.

*

SULPHUR in doses of 5 grains three times daily is almost specific in perverted nutrition of the nails.

*

PURE bromide of strontium in doses of a drachm a day is said to be very effective in diabetes mellitus.

*

THE As-Par-O-Line compound of Wampole, the formula of which is on every bottle, is used with great success in dysmenorrhea and leucorrhea.

*

ALCOHOL, according to Dr. Wood, is contraindicated in shock. While, as he says, it stimulates the heart it paralyzes the blood vessels, and by its action on the blood cells checks oxidation.

*

ACETANILID is said to be a good substitute for iodoform as a surgical dressing. It seems to be especially adapted to lacerated and contused wounds contaminated with dust, oil, etc., such as occur in mechanical pursuits.

*

SALINES operate in three or four hours. Croton oil in one or two hours. Jalap, gamboge and senna in three or four hours. Rhubarb and castor oil in from four to six hours. Aloes and mandrake in from ten to fourteen hours.

READING NOTICES.

Celerina. — Dysmenorrhea, the congestive kind, with stomachache, and excruciating headache and pain in the back, which is often seen in young girls and women with displacements, can often be relieved by Celerina and Aletris Cordial combined, in equal parts.

*

Cholera Infantum.—Physicians coincide in their views regarding the treatment of the summer diarrhea of infants and children to a degree that enables it to be thus briefly summarized: Diet, emptying the alimentary tract, antisepsis. For the antiseptic treatment, Listerine alone, or Listerine, aquæ cinnamon and glycerine, or, Listerine, bismuth and misturæ cretæ, will meet many requirements of the practitioner during the summer months.

The following well-tested formula is submitted:

℞ Listerine. . . . . ʒj—ij
Simple Syrup. . . . . ʒvij—vi—M.

Sig. Teaspoonful every two or three hours.

℞ Listerine.
Glycerine (c. p.).
Syr. Simpl.
Aquæ cinnamon, aa ℥i.—M.

Sig. Teaspoonful every one, two, or three hours.

*

Hæmoferrum.—A palatable preparation of iron that is at the same time readily soluble, easily assimilated, and that does not constipate, has been the desideratum of physicians for all time and many compounds have been devised without being able to fill all of these requirements. It is natural to suppose that any physician who keeps abreast of the times, and is interested in the advances made in pharmaceutical preparations, will eagerly avail himself of the opportunity to obtain samples of an iron preparation that possesses the above requisites besides being neutral in reaction, agreeable in odor, non-styptic and non-poisonous even in large quantities. Hæmoferrum (Blood Iron) manufactured by Frederick Stearns & Co., Detroit, Mich., is the preparation above referred to, and the manufacturers will be pleased to mail a sufficient quantity for a thorough clinical test to any physician who is unacquainted with it, together with full literature and clinical reports.

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ORIGINAL ARTICLES.

SOLUTION OF BROMIDE OF GOLD AND ARSENIC IN THERAPY.

Read Before the Tri-State Society, Cumberland, Md., June 28, 1894.

By W. F. Barclay, M. D.,

Pittsburg, Pa.

Solution of bromide of gold and arsenic is a definite compound of gold, arsenic and bromine in aqueous solution. It is slightly acid in reaction, the color is garnet, and it is so formulated that 10 drops of the solution is equivalent to $\frac{1}{32}$ of a grain of gold bromide and $\frac{1}{32}$ of a grain of arsenic bromide.

It is a stable solution and will not deposit with ordinary care. Neither light nor heat affects it, but cold, at a very low temperature, will congeal it; thawing restores it to its normal condition.

Much has been said and written about this preparation so far as its chemical properties and composition are concerned. But I am pleased to state that no one has had the audacity to deny that it, chemically speaking, is just what its name implies.

A well-known New York pharmaceutical firm have with great pains and care placed it before the medical profession in a form that must recommend it as one of the carefully and accurately compounded preparations of medicine.

Now before the medical profession I am constrained to state that over fifteen years ago, while listening to Prof. J. S. Wight lecture upon the subject of cellular pathology, in the Long Island College Hospital, Brooklyn, N. Y., this compound suggested itself to my mind as a possible remedy that might be most useful in the correction of certain pathological conditions. That these conclusions were correct has been more than satisfactorily demonstrated in my own experience in the treatment of diseases, as well as that of a large number of the most distinguished members of the medical profession.

This preparation of medicine, like many, is no doubt likely to be applied where it is contraindicated and must disappoint the physician and his patient. The purpose of this paper is to point out to the profession some pathological conditions in diseases which can be removed by its use.

To cure diseases is to correct pathological conditions, restore physical action and normal function.

There are perhaps no diseases that confront and perplex physicians as do the disturbance of digestion and assimilation. To Prof. Bartholow is due the credit of first pointing out the use of gold in the treatment of these diseases. And as to the use of arsenic in these affections it would be impossible for one to even attempt to designate the large number of medical men who have, after the most careful and painstaking observations, recorded their approval of the

use of arsenic in the treatment of diseases of digestion, assimilation and nutrition. Hence it is that in the union of gold and arsenic with bromine, we have, I am entirely safe in saying, one of the most valuable remedies ever offered to the profession.

I can with the greatest confidence state that it will seldom fail to give the greatest relief in all diseases of functional disturbances as well as correct faulty secretion.

I am in the habit of giving Papoid in small doses (2 gr.) before meals in the outstart of the treatment with, I am satisfied, decided benefit.

I generally after two or three weeks discontinue it and continue the gold and arsenic until entire relief is given and a cure effected.

What is the action of gold? We are told it acts much like mercury by all medical writers who have mentioned it at all.

It is certain that we can arrive more readily at an approximation of its action by an analogy than in any other way. Mercury acts as a depressant upon the vital powers. Gold acts as a stimulant.

The stimulating effect of mercury upon the secretions is secondary, that of gold is primary. Mercury always impairs digestion, assimilation and nutrition. Gold always improves these functions.

The poisonous effects of mercury are of long standing, frequently permanent.

The poisonous effects of gold (if, indeed, it has any) in proper combinations soon pass off.

I may here say I have given from forty to sixty drops of solution of bromide of gold and arsenic without any noticeable injurious effects by the hypodermic method.

I have given in intractable cases from forty to sixty drops four times a day without noticing any unpleasant effects from its use.

I believe the average dose of ten drops given three or four times a day ordinarily gives the best results.

Mercury acts disastrously upon the protoplasm of the blood, it lessens the red corpuscles, and, if long continued, causes mercuric fever and brings on a depressed state of vital action, from which the patient reacts slowly, and not as a rule without the aid of well-directed tonic treatment.

Gold acts as a stimulant to the brain and nervous system. A sense of exhilaration quickly follows its administration, thought and action are stimulated, the heart pulsations are increased, the volume of blood pressure is regulated and equalized, the red corpuscles are increased, the color and warmth of the skin are improved and it regulates and equalizes the secretions.

Mercury produces diarrhea, which is followed by pallor, and coldness of skin and extremities. The enlarged coated tongue, constipation of the bowels, an enlarged and torpid liver, foul breath, dilatation of the stomach, are restored to their healthy condition by the use of gold and arsenic. Natural sleep is induced, producing rest and comfort.

The advances in therapy teach us that in many instances chemical union of several remedies is most advantageous. In the study of chemical affinity the selection of the combination that is most easily absorbed is of vital importance. In this compound we have one that is almost instantaneously absorbed into the circulation of the blood. These elements have been detected in the urine thirty minutes after its administration.

From these observations we deduce the truth, that there is no resemblance between the action of gold and mercury except that ptyalization is said to have been observed in preparations of gold hitherto in use. I have not seen such effect from the use of large doses of solution of bromide of gold and arsenic.

No law of the healthy processes of life can be changed without the impairment of normal function.

It is that intimate and correct knowledge of the physical laws of life that enables the diagnostician to discern if there is any deviation from that which we call health.

A pathological condition suggests remedies and it is from a careful study of the action of medicines that we deduce correct therapy.

Arsenic is an old remedy and its action upon the system has been so carefully studied and well understood that a mere reference to the diseases in which it has been found useful is considered sufficient in the study of gold, arsenic and bromine.

The beneficial action of small doses of arsenic upon the digestive system have been recognized and well understood.

Its action upon the nervous system is no doubt attributable to its influences upon the digestive system and not as a primary nerve tonic (improved assimilation of food and increased appetite). It acts as a stimulant upon the respiratory system and renders respiration easier; its effects are well understood by those persons who desire to ascend high mountains and breathe in a rarefied atmosphere.

It is more used than all other remedies for its action upon the cutaneous system. The edema arsenicalis is a curious symptom and seems to be at variance with the views of most observers, as to its action upon the skin and mucous membranes. This symptom I have not observed upon its long, continued use with gold and bromine.

It is a stimulant to the glandular system and increases the secretions of those glands through which it is eliminated.

It acts as a stimulant to the genital and urinary organs, it increases sexual power and urinary secretion.

That arsenic enters into both food and drink is a fact, and does so not to the injury of health, but to its improvement, is true.

I do not care to enter into its poisonous effects, as we only care to use it in therapy and not in toxicity.

I will briefly mention some of the diseases in which it is useful in lupus, epithelioma, sarcoma and enchondroma.

In consumption, in bronchitis and in all suppurative diseases arsenic is useful and curative, but it is sometimes condemned on account of its trying effects upon the digestive system in large doses, which we obviate by its union with gold and bromine.

Let me quote the words of Dr. Bartholow, "We have no single drug of equal utility in chronic forms of phthisis."

As a tonic in the strumous cachexia, in diseases of lymphatic structures, and especially in the diseases of the adenoid tissues it is most useful. In chlorosis and progressive pernicious anemia and in simple anemia it is a remedy to be depended upon.

As to bromine, it is a remedy in combination with other agents most easily and readily absorbed.

The bromides, it would seem, are soon to displace the chlorides and iodides on account of their ready absorption and pleasant effects upon the digestive system.

The action of bromine is so well understood that it is deemed sufficient to state that it is readily absorbed and speedily eliminated without irritation to the structures through which it passes out of the body.

We have for consideration the combination of gold, arsenic and bromine—liquor auri et arseni bromidi in therapy.

It is readily absorbed, agrees well with the digestive powers in correct doses when properly administered in water. Its ready absorption is guaranteed by its being well diluted. It is my custom to direct ten (10) drops in half wine glass of water three or four times a day. The hypodermic use is a guarantee of its speedy action and should be resorted to in all cases where such action is required, as well as in all intractable cases.

The hypodermic method produces neither pain nor irritation when properly injected into the muscular tissues in the subscapular and gluteal regions.

In all diseases of the digestive powers this solution is indicated and will give the most gratifying results.

In dilatation of the stomach, which is generally present in all cases of impaired digestion, it acts as no other remedy in my hands has done.

Its primary action is upon the protoplasm of the blood, the blood vessels are restored to healthy action by an improved nutrition, better blood pressure, and an increased enervation.

The hyperplasias caused by exudation and deposit are removed by the correc-

tion of their causes and rapid absorption.

It is a fact well established that most exudative deposits and hyperplasias are directly traced as to their causation to the stomach, liver and bowels—malassimilation of food and malnutrition of the body are the first causes.

The primary causes by proper medication and a well-directed regime is all-sufficient to cure the major part of these ailments. The continual activity of the absorbents is sufficient to throw off these exudative deposits.

Perhaps, if we better understood the albumen of the blood and its physiological properties and its use in the building up of healthy tissues in our bodies, we could better comprehend the causes of deposits in different parts of the body which are not at present well understood.

The materies morbi in phthisis pulmonalis are sometimes found in the meninges of the brain and the spinal cord. At other times in the omental structures underneath the peritoneum covering the bowels, indeed almost all the structures of the body may be the seat of tubercular deposit, but never outside of the lymphatic system.

We are certain of the deposit and its chemical character and that it is a foreign substance attended by most disastrous consequence as a rule.

It is a well established fact that it frequently is thrown off by the process of absorption and does no harm to the patient.

The first cause is yet a question of doubt in the minds of many. Some believe that the bacillus tuberculosis enters the circulation and that in its exit through the lymphatic system it takes its lodgment and there does its fatal work. Others believe it is entirely caused by faulty digestion, assimilation and nutrition.

This latter view seems to be strengthened somewhat by the well-known views taken by many in regard to nodosities in different parts of the body, especially about the joints.

These seem to be easily traced to impaired digestion caused by dilatation of the stomach, that impaired digestion is caused by dilatation of the stomach and this can be stated as always accompanied by enlarged liver and an impaired function and secretion of this organ.

That the old writers on medicine were correct in their views, that a diseased liver had much to do with many diseases and that in the main they were correct in their treatment directed to correct such faulty action was no doubt correct in theory and in practice.

The fact is better understood when we consider that the quantity of bile secreted is equal to, if not greater than, that of the urine. The liver is the great depurative gland of the body. Impairment of its normal function must act most disastrously upon the entire system. We direct gold and arsenic solution in the treatment of hyperplasias in the superficial structures and have the satisfaction of seeing them disappear and the natural size restored as well as the restoration of normal functions. Hence it is that we deduce the conclusion that we may expect the same results upon the occult structures.

In adenitis of the superficial glands we give these solutions and observe that our patient gets well.

With great confidence we apply the same treatment in enlarged liver, kidneys, spleen, pancreas, and secure the most satisfactory results.

The old law laid down is true then as now, that good health and impaired secretions and elimination by the glands of the body are inconsistent.

Hence we deduce from our observations of these functions of the body in diseases that they are restored to healthy action; that it is well directed treatment to give solution of bromide of gold and arsenic.

In consumption, in bronchitis, in scrofula and all suppurative diseases, gold, arsenic and bromine are useful and curative and cannot be condemned on account of their unpleasant effects upon the digestive system.

Dr. Bartholow states that we have no single drug of equal utility when he speaks and writes of arsenic in phthisis. I would add to this evidence the statement that solution of bromide of gold

and arsenic in this disease is so much more useful and curative in the different stages of phthisis pulmonalis that I can with the greatest assurance state that in my hands it is a specific.

When I observe all the signs and symptoms improved in the treatment of consumption, I must conclude that this remedy is the only one in our armamentarium of which I can truthfully say that it is curative and can be depended upon when properly administered.

Phthisis pulmonalis in its course may be divided into three stages.

The primary stage is that of infection, the secondary stage is that of deposit, inflammation, suppuration and disintegration. The tertiary stage is that of cough, copious expectoration, night sweats, diarrhea, hectic, cavities, loss of appetite, rapid prostration and death. The first two stages under proper treatment, hygienic care and climatic influences are curable.

The third stage is more grave and it is here that the best results are derived from climatic influences with proper care and treatment.

I am in the habit of using a compound (guaiacol spray) with a hand atomizer with, I believe, excellent results. It should be used two or three times a week; the patient should be taught how to practice forced inspiration in the open air, as I believe this is a most valuable aid in the treatment of the disease.

The observations made by my esteemed and learned friend, the late Dr. E. A. Wood, of Pittsburg, in a paper read before the South Side Medical Society of Pittsburg, are well known from a reprint of the paper which has been widely circulated and generally read.

To Dr. E. A. Wood's memory be it said that he was the first to direct the attention of the medical profession to the use of this remedy in the treatment of consumption.

Dr. Wood read a paper before the Mississippi Valley Medical Association in October, 1893, on "Gold in Therapy," in which he called the attention of the profession to this new remedy.

Dr. Wood was so widely and favorably known in the profession that anything coming from him was certain to be well received and much appreciated. It was always said of him that he was one of the most careful and accurate observers in the profession.

Nothing would pass him in therapeutics and receive his approbation without the most careful observation and test as to its intrinsic merits.

All therapy is based upon correct observations on the action of medicines. It is not possible to make such observations in a few months as will justify me in setting forth the largest utility of this solution, but sufficient has been written by others upon its use to enable me to state with a large degree of certainty as to its application in all pathological, neurotic and sclerotic conditions.

A mere mention of the diseases in which it will prove useful in most instances is all that I can claim to do in a short paper such as this must of necessity be.

The rule is that disease is established and has made considerable progress before the physician is consulted, and he has not had the opportunity to observe and consider the changes that take place in the vital functions in the outstart.

It has been asserted that no one enjoys perfect health and when we consider our environments it would seem to be true. The constant warfare that must take place in our bodies when we consider the innumerable causes that tend to impair health we can but be amazed that the vital forces suffer as little as they do.

Certain causes always produce the same results modified to a greater or less extent by individual power of resistance and environment.

The cause of all contagion is specific and its effects upon the organism and the results after it is once implanted in the body are almost identical.

Hence it is that the same treatment in each disease is applicable and gives the same results.

We are sometimes called routinists and it is far the best interests of our patient that demands it. It is a rare chance to find a practitioner of a quarter of a century's experience who exceeds

the number of years of his professional career in the drugs used in his practice. Hence it is in introducing a new compound we do so with profound hesitation. The multiplicity of drugs and compounds upon the market is calculated to confuse the minds of medical men, and lead to skepticism as to their uses. The greater part of medical compounds upon the market today are the results of the labors of so-called chemists and pharmaceutists, men who know nothing whatever about the action of medicines and care less except to enrich themselves.

The medicines and medical compounds that have stood the tests of fair trial in the treatments of diseases have all come from the labors of physicians who have associated the study of pathology, chemistry and therapy.

The names of such men as Magendie, Lugol, Fowler, Donovan and others are immortal.

That scrofula is the result of an inherited taint of specific origin is a truth established by the observations of the most eminent authorities in the medical profession.

Weakened and enervated primordial cells produce an organization that has little vital power of resistance and must suffer from a continual predisposition to decay.

We could not mention this truth without entering into a consideration of the effects produced by the transmission of such primary diseased vital cells. That the first cells of the protoplasm that builds the organization modify the physical life of the new being cannot be questioned. Hence it is that the sins of the fathers are visited upon their children.

If we can by proper medication eradicate disease and produce healthy primary cells, may we not at least reasonably hope to correct to some extent the evils that fall upon posterity ?

In all scrofulous affections I believe solution of bromide of gold and arsenic will give better results than any remedy with which I am acquainted. It can be administered for long periods of time without (as far as my observations go) any injurious effects upon the system.

In diabetes and Bright's disease it is curative, in epilepsy, chorea, hystero-epilepsy, paralysis agitans, and puerperal mania it will seldom fail to give relief and effect a cure. I have given it in goitre and exophthalmic goitre; I have made a number of gratifying cures, where other treatment had proved useless.

In diseases of the skin, without going into a special mention of its adaptation, it may be mentioned that where the dermoid glands are in a state of congestion an enlargement and the intercellular tissues are loaded with lymph it will be highly beneficial. In acne it can be relied on to give relief with proper directions as to local care and treatment of the skin. In the general treatment of ulcers of long standing it will seldom fail to cure with proper local treatment. Neurasthenia, nervous prostration and insomnia demand its use with rest.

In all the diseases of the nervous system, acute or chronic, it is equally useful. In neuritis, in neuralgia, gastralgia, cardalgia, angina pectoris, tic douloreux, pericrania, hemicrania, tri-facial neuralgia and especially in that form of periodic headache so common, it is a specific.

In sclerotic diseases of the spinal cord, paralysis, locomotor ataxia, and where all treatment usually is unavailing, it will remove the cause and restore the normal functions of the spinal cord, where the structure of the cord is not destroyed.

In cases where a specific cause is suspected or known the liquor auri arseni et hydrargyri bromidi should be used. In all sclerotic diseases of the glandular system, in adenitis with a diseased lymphatic system, lymphangitis with impaired elimination, also enlarged liver, kidneys, spleen and pancreas, especially where a malarial cause has been present, no remedy is more reasonably indicated and none will give better results.

It has been prescribed in phlegmasia dolens and puerperal mania, with a speedy improvement and cure. It has been satisfactorily given in the convalescence from the eruptive diseases, measles, scarlet fever in those cases where there is glandular enlargement and a tendency to the formation of abscesses. In the

digestive troubles attending dentition of children one to three drops three times a day will give the happiest results. In arthritis and chronic rheumatism, as well as all atheromatous conditions, it has received the most favorable recommendations from the medical profession.

The gold solutions should always be dispensed in glass, as contact with metallic substances immediately deposits them. They are incompatible with most preparations and should never be combined with other medicines.

From a most careful observation of the use of solution bromide of gold and arsenic, I can state we have in it a remedy of far more value than mercurial iodine or vegetable alteratives, in that it acts upon the digestion, assimilation and nutrition of the body as well as the metabolism of the blood, as no preparation of medicine does. It stimulates all the functions of the vital forces and at the same time does so without disturbance of or any derangement of the natural laws of the body.

It passes through the circulation, and there is no noticeable excitation in any of the functions, but there is a general improvement in the tone and vigor of all with a noticeable improvement of vital power.

Life is too sacred to be lost, and health is too important to its possessors to be impaired to even cause a good physician to make statements that have not been carefully weighed, and fully verified in his own experience as well as that of others. It is, therefore, with these considerations before my mind as well as a great desire to have you more than fully verify my observations in your own experience, that I have written this paper. I covet your approval if I am right, and ask your charity if you honestly find me wrong in the statements which I have made.

[After the reading of this paper it was moved that a vote of thanks be tendered Dr. Barclay for his scientific and able production by the Tri-State Medical Association and carried unanimously; it was again moved that a copy of the address be requested of Dr. Barclay to be made a part of the archives of the Association, and carried unanimously.]

THE PREPARATION OF THE FINGERS AND NAILS FOR SURGICAL OPERATIONS.

Read Before the Philadelphia County Medical Society, June 13, 1894.

By Oscar H. Allis, M. D.,
Surgeon to the Presbyterian Hospital, Philadelphia.

The nails form no mean part of a surgeon's outfit. As a covering to the end of the finger they give confidence; in the threading of needles they are often indispensable; while often, when working among adhesions, they may serve a good turn. If the nails are too long they are in the way, and if too short, a privation. A medium length of nail is an exceedingly valuable helper at times. With some the length of nail is governed by the ability to keep it clean. Hence the nail is kept very short—much to the disadvantage of prehension, in which man excels.

The surgical care of the nails has had its full share of attention. The nail-brush forms a part of every physician's and surgeon's outfit. It is cheap, compact, and moderately thorough. Its disadvantages are that if stiff it is apt to scratch the hand or cut beneath the nails; if soft, it is of little value. To supplement the defects of the brush, some persist in using the point of the nail blade of their pocket-knives. I say persist in using—as much has been written against the practice. Not only is there danger of cutting the flesh beneath the nail, but it leaves the under surface of the nail rough, making it a ready collector of filth, and less easily cleaned for a subsequent operation.

To avoid the knife I have long used

a little wedge-shaped piece of soft pine. This, when wet, frays up, makes a kind of mop, is a good carrier of soap, and enables me to wash out under the nail. The objection to my device was that the pine rapidly frayed out, became bulky, and required frequent trimming. Finally I hit upon the rubber eraser. A variety is made for artists and school-children that is wedge-shaped. This is ready for use as it is found at the stationer's, though if made a little sharper it is softer and more like a mop. It is pliable, soft, and an excellent carrier of soap.

For the hand, generally the old-fashioned wash-rag cannot be improved upon. It is a good carrier of soap, and with it each finger in turn can be tightly caught and wrung until clean. With the nail- or hand-brush only the back and front of the fingers get the scrubbing.

In addition to the implements usually deemed important for the cleanliness of the under surface of the nails, a very valuable one is the nail itself. Noticing that a young lady's fingers whom I frequently met were always exceedingly neat, I made bold to ask her methods, and was surprised to find that she had nothing more modern than a pair of scissors to trim her nails, and that with wash-rag and the tips of her finger-nails she kept her hands in most perfect order. One thing that may be said of the finger-nail as a nail-cleaning instrument, is that it will not scratch the under surface of the nail, a very important factor in the process, whether one aims at beauty or cleanliness.

Hygiene is the proper thing in infantile diarrhea according to Dr. J. C. Griffin in the *Medical Summary*. Too much milk should not be given and it should always be boiled. If it is not well borne, a small piece of lean beef to which a little brandy or whiskey has been added will be retained and digested. Open the bowels with castor oil and then give the following:

℞. Hydrarg. chlorid. mit. . gr. vi
Cretæ preparatæ . . gr. xij
Opii pulv. . . gr. j
M. ft. in chart. No. xii. Sig.—Give one powder night and morning.

℞. Zinc. sulpho-carbolate,
Sodii bicarb. . aa gr. v
Creasot. (beechwood) . gtt. v
Cretæ preparatæ. . gr. x
Acaciæ. . . ʒss j
Aquæ cinnamomi q. s. ad. ʒiss ij

M. Sig.—Give one teaspoonful after each action, and as soon as the bowels seem to be under control continue every hour for three or four hours, and then lengthen the intervals.

Cupric sulphate in minute doses as recommended by Aulde has been successful in some cases.

Gonorrheal Peritonitis.—Chaput (*British Medical Journal*) reports the case of a girl, aged 17, who had suffered from abdominal pains for a fortnight, and was admitted with all the symptoms of very acute peritonitis. Abdominal section was performed. A quantity of creamy yellowish pus was found in the pelvis; the entire intestine was congested. On raising the right Fallopian tube, it was found to be dilated. Its fimbriæ were deeply injected. On pressing the tube with his fingers, Chaput caused a drop of creamy yellowish pus, of the same appearance as that in the pelvis, to issue from the ostium. The same condition was detected in the left tube. In order to protect the peritoneum from the septic stumps of the tubes when the appendages were removed, Chaput left the ends of the ligature silks hanging out of the abdominal wound, and a strip of iodoform gauze was pressed into Douglas's pouch. The patient in a few days had obstruction from paralysis of the intestine. An artificial anus was made, but afforded no relief, and the patient died. No mechanical obstruction could be found; the violence of the peritonitis had caused paralysis of the intestine.

HOSPITAL REPORTS.

ANNUAL REPORT

OF THE LYING-IN HOSPITAL OF THE UNIVERSITY OF MARYLAND, BEGINNING MAY 1, 1893, ENDING MAY 1, 1894.

J. Edwin Michael, A. M., M. D., Senior Obstetrician; Kemp Battle Batchelor, M. D., Junior Obstetrician; Otis Bush Stone, M. D., Senior Resident Physician; C. W. Larned, M. D., Junior Resident Physician.

Average number of cases seen by each member of the graduating class, 8.57.

Greatest number seen by any one student, 17.

Least number seen by any one student, 5.

Number of confinements in hospital, 150; number of confinements in out-door department, 155; total, 305.

Male births in hospital, 70; male births in out-door department, 86; total, 156.

Female births in hospital, 67; female births in out-door department, 76; total, 143.

Cases in which sex was not recorded, 12; total, 311.

Cases of twins in hospital, 3; cases of twins in out-door department, 3; total, 6.

Premature deliveries in hospital, 12; premature deliveries in out-door department, 6; total, 18.

Abortions in hospital, 5; abortions in out-door department, 7; total, 12.

Still-births in hospital, 5; still-births in out-door department, 18; total, 23.

Maternal deaths in hospital, 2; maternal deaths in out-door department, 0; total, 2.

Infantile deaths in hospital, 7; infantile deaths in out-door department, 7; total, 14.

Normal temperature in hospital, 82; normal temperature in out-door department, 96; total, 178.

Cases that were not above 100° F. more than one day, in hospital, 12; cases that were not above 100° F. more than one day, in out-door department, 23; total, 35.

Cases that were not above 100° F. more than three days, in hospital, 15; cases that were not above 100° F. more than three days, out-door deparment, 10; total, 25.

Distinctly septic cases in hospital, 1; distinctly septic cases in out-door department, 8; total, 9.

Cases of mastitis that did not go on to suppuration, in hospital, 12; cases of mastitis that went on to suppuration, in hospital, 3; cases of mastitis, in out-door department, 5; total, 20.

Cases of eclampsia, in hospital, 3; cases of eclampsia, in out-door department, 3; total, 6.

Cases threatened eclampsia, in hospital, 3; cases threatened eclampsia, in out-door department, 0; total, 3.

Malarial cases, in hospital, 14; malarial cases in out-door department, 5; total, 19.

Pleurisy, in hospital, 1; pleurisy in out-door department, 1; total, 2.

Grippe, in hospital, 6; grippe in out-door department, 1; total, 7.

Rheumatism, in hospital, 1.

Ophthalmia neonatorum, in hospital, 0; ophthalmia neonatorum, in out-door department, 11; total, 11.

Post-partum hemorrhage, in hospital, 0; post-partum hemorrhage, in out-door department, 3; total, 3.

Forceps in hospital, 17; high forceps, 3; low forceps, 14; forceps outdoor department, 7; high forceps, 3; low forceps, 4; total, 24.

High forceps applied to an after-coming head in a breech case, 1.

Versions, internal podalic (both in out-door department), 2; delivery of frank-breech with blunt hook (in hospital), 1; perineorrhaphies, in hospital, 13; perineorrhaphies, in out-door department, 2; total, 15.

The fatal cases: The two fatal cases are recorded below.

CASE 1. *Eclampsia.* Mollie Brown, æt. 27, white, single, para 1. Admitted August 2, 1893. Confined August 14, 1893. Diagnosis R. O. I. P. Urine examined twice previous to labor and found to contain albumen but once. Patient had considerable edema of extremities; micturition very frequent, etc. On August 14, at 3 A. M., labor began,

which was somewhat prolonged, owing to uterine inertia, and patient was finally delivered with forceps by Dr. C. W. Larned, after which the usual precautions againt post-partum hemorrhage and septic infection were observed. At 5.15 P. M. of same day, convulsion occurred. Patient was given immediately veratrum viride, minims xv., morphia sulphate, gr. $\frac{1}{6}$ and $\frac{1}{8}$, hypodermically; also potassium bromide, gr. xxx, and ergotole, minims xx. The veratrum viride reduced the pulse from 120 to 60. Catheterized immediately after convulsion and the urine was found to be nearly solid with albumen. Patient was given pilocarpine muriate, gr. $\frac{1}{8}$ hypodermically and a vapor bath for about fifty-five minutes, after which she was much improved. Patient was put on infusion of digitalis, $\frac{1}{2}$ oz., and pilocarpine muriate, gr. $\frac{1}{8}$, every four hours; potassium citrate, pulv. jalap, co. etc., with veratrum viride according to indications of pulse.

August 15: Albumen not diminished. Treatment same as preceding day. Milk diet. Condition of patient improved. Catheterized, albumen diminished about half.

August 16: Catheterized, albumen diminished. Patient much improved. Treatment same as previous day.

August 17: Condition in A. M. improved, but toward evening patient became drowsy. Dry cups at 7.25 P. M. Otherwise, same treatment as preceding day.

August 18: Condition, drowsy. Vapor bath given at 12.15 P. M. for fifty-five minutes, after which patient remained in profoundly comatose condition, with pulse bounding and rapid. Muriate of quinine and urea, minims xx, given to relieve pulmonary edema. At 1.25 P. M. put patient on infusion of buchu and gave another vapor bath for thirty minutes. Condition not improved. Stimulants ordered. Milk diet, other treatment continued.

August 19: Condition very low. Treatment suspended and patient stimulated by hypodermic injections of whiskey and strychnia sulphate, gr. $\frac{1}{30}$, also nitro-glycerin, gr. $\frac{1}{100}$. Patient died at 3.15 P. M.

Temperature from August 14 to August 17 varied from 98° to 99$\frac{4}{5}$°. On August 18 it began to rise rapidly, reaching 104$\frac{3}{5}$° on August 19, at which time the patient died.

Pulse ranged from 70 to 80 during the time from August 14 to 18, and on August 18 P. M. and August 19 rose rapidly to 142, which was maintained until death.

Child was born asphyxiated but was resuscitated.

CASE 2. *Eclampsia.* Frances Carter, æt. 19, colored, single. Para 1.

Patient was brought to hospital in ambulance in condition of profound coma, being pulseless at wrist, on September 13, at 9.30 A. M. Friends gave history of twenty-seven convulsions during preceding twenty-four hours. Labor had begun on September 12, at 6 A. M. Pulse on September 13, at 9.30 A. M., 140. Examination revealed membranes ruptured, and os dilated to size of a quarter. Vertex presentation, L. O. A. position. Patient was anesthetized and attempts made by Drs. Michael and Larned to dilate os with fingers, but without much success. Dr. Michael then cut edges of os with scissors and Dr. Larned applied high forceps and delivered male child, weight four pounds, fifteen ounces; child was dead.

Meanwhile was giving the following: Chloral hydrate, gr. xx, potassium bromide, gr. lx, per rectum; morphia sulphate, gr. $\frac{1}{2}$, and whiskey, minims xx, hypodermically. Urine was loaded with albumen; patient very edematous to the extent of pulmonary edema. After delivery patient was stimulated with strychnia sulphate, nitro-glycerin and whiskey, hypodermically. Gave muriate of quinine and urea for pulmonary edema. Applied three dry cups over each kidney. The usual precautions against septic infection and post-partum hemorrhage were observed.

On September 13, at 7.15 P. M., patient showing symptoms of impending convulsions, a few whiffs of chloroform were administered and morphia sulphate, gr. $\frac{1}{4}$, hypodermically. Patient was put in hot

pack at 8 P. M. Catheterized three times: 9.30 A. M., 6 oz.; 3.30 P. M., 1 oz. and 11.15 P. M. Last urine very scant and contained very little albumen.

Patient died at 12 o'clock, midnight.

Temperature: 2.30 P. M., 104.2°; 4.45 P. M., 105.8°; 11.30 P. M., 106.6°.

Pulse: 11.15 A. M., 140; 2.30 P. M., 108; 7.30 P. M., 154.

Remarks: The circumstances under which the clinic is conducted render the patients peculiarly liable to septic infection; and it is thought to be very creditable to have gone through the year without a septic death, and with such a very small proportion of septic morbidity. The hospital is a private dwelling which has been modified to suit the purposes of the clinic and is therefore not provided with those elaborate arrangements of which more wealthy institutions can boast. For example, the lying-in room is so situated that it is more or less a thoroughfare, and is at the same time the only room in the house suitable for the purpose. There is space only for one white, and one colored lying-in ward. The waiting-rooms are necessarily crowded beyond their proper capacity, and the isolation-room, while well separated from the rest of the house, is by no means satisfactory. The clinical material is also to be considered. While the majority of the patients are properly prepared for delivery, many come in from the streets actually in labor and in a most filthy condition. Moreover, all of the patients are subjected to repeated examinations (since they are used for purposes of clinical demonstration) and, although every effort is made to prevent students and nurses from infecting the patients, there is no doubt considerable danger from this source. The out-patient material is handled under somewhat different circumstances, but, nevertheless, presents many difficulties. Many of these patients are attended in hovels of the most filthy character and are conducted through their puerperia under the most unfavorable conditions. The absence of fever as reported above, among this class of patients, is due to the negligence of students in making accurate reports of their outside work. As a matter of fact, there is decidedly more sepsis among the outside patients than among those in the Hospital. Attention should be called also to the difference in the frequency of ophthalmia neonatorum as observed among the out-patients as compared with those in the Hospital, where the Credé preventive method is rigidly carried out. In the Hospital, ophthalmia is practically eliminated and no evil results are reported as due to the use of the method, while in the out-patient department the disease is by no means uncommon.

SOCIETY REPORTS.

THE AMERICAN MEDICAL ASSOCIATION.

FORTY-FIFTH ANNUAL MEETING, HELD IN SAN FRANCISCO, CALIFORNIA, JUNE 5, 6, 7 AND 8, 1894.

Specially reported for the MARYLAND MEDICAL JOURNAL.

FOURTH DAY, JUNE 8, 1894.

THE first paper presented was entitled A NEW PLASTIC OPERATION FOR VARICOCELE, with presentation of case by Dr. O. Mayer, of San Francisco. The feature of the operation is the transverse suturing of the longitudinal wound, which method considerably shortens the scrotum. A case which had been separated was presented.

Dr. Mayer also read a paper on A BLOODLESS VAGINAL MYOMECTOMY, the essential step in the operation being the temporary ligation of the uterine arteries.

A very interesting and instructive paper was presented by Dr. G. W. Woods, of Mare Island, California, on THE USE OF ACETANILID IN MEDICINE AND SURGERY, with special reference to its use in minor surgery. The speaker gave a brief account of its preparation and composition. Antifebrin, he said, was simply another name for acetanilid. It is a good antipyretic and not poisonous even to children if given in small doses at the commencement. It acts slowly and is both a diaphoretic and diuretic. It may be given in any and all fevers and inflammations. It is a good substitute for iodoform in venereal

sores. It is useful in the dressing of all forms of burns, ulcers, moist eczema, gunshot wounds, abscesses, etc.; when applied to extensive granulating surface it sometimes produces cyanosis, which is not due to a disturbance of circulation but to a deficient oxygenation of the blood. Acetanilid is exceedingly useful, because it is cleanly, odorless, antiseptic, dessiccating, practically non-toxic, does not crust, is easily removed, and not altered by moisture.

A paper by Dr. Thomas, of Pennsylvania, on How Long is Syphilis Contagious? followed. The speaker emphasized the fact that he was perfectly convinced that syphilis is only contagious in the primary and secondary stages, that is, only for three or four years after the primary lesion.

Dr. Bounwell, of Philadelphia, Pa., read a paper on A Surgical Engine. This engine, which was very similar to the ordinary dental engine, caused the trephine or burr to revolve from 100 times to 20,000 times a minute. It is said to be adapted to the performance of all sorts of surgical operations, both of the soft parts and of bony tissue.

Section on Gynecology and Obstetrics.

First Day, June 5, 1894.

The importance of this section is assuming gigantic proportions. Many of our ablest men were present and contributed to the work.

The section was called to order by Dr. J. Milton Duff, who introduced Dr. Jos. Eastman, of Indianapolis, president of the section.

Dr. Eastman, in his address, spoke of an operation which is original with him, viz., that of suprapubic hysterectomy. The method was illustrated by means of diagrams, some of the instruments used —the hysterectomy staff, and the serrated gouge, and also by tumors which had been removed by this method. The process consisted in tying the uterine arteries in the broad ligament close to the cornua of the uterus and then separating the peritoneum and subserous tissues from the uterus, leaving the uterine arteries in the pelvis. The advantages claimed are, the slight hemorrhage and the greatly diminished liability to septic infection by having no ligatures in the abdominal cavity. In closing the abdominal wound, he said that the surgeon should expend greater efforts upon the proper suturing of the peritoneum than upon the external appearance, so that the wound will drain outwardly and not into the abdominal cavity. He prophesied that in the near future the death-rate from the removal of fibroids will be reduced to an equality with that of the removal of ovarian cysts.

On motion, a vote of thanks was tendered the President, and his paper requested for publication. In the absence of the Secretary, Dr. Newman was appointed Secretary *pro tem.*

Dr. Franklin H. Martin, of Chicago, then read a paper on Operative Treatment of Fibroid Tumors of the Uterus, in which he made a summary report of six previously published cases, and a first report of two recent cases, of his new operation for fibroids.

Following are the conclusions of the paper :

1. In hysterectomy we have an operation which is bearing the test of time well ; in selected cases in the hands of well trained men it is the only absolute cure yet demonstrated for a certain class of fibroids.

2. The objections to hysterectomy as a cure for fibroids are the long training necessary to safely equip an abdominal surgeon for this most formidable of pelvic operations, the great death-rate of this operation in the hands of the tyro, the long prostration accompanied frequently with nervous symptoms following otherwise successful hysterectomies, its inapplicableness to extremely exsanguinated and otherwise reduced patients, and finally, its inevitable death-rate of at least five per cent. in the hands of expert surgeons.

3. Removal of the appendages as an operation for fibroids is usually unsatisfactory, and should not be resorted to ordinarily except as a last resort in a complicated case when the abdomen has been opened for the purpose of removing

the uterus, and the latter operation for some reason has proved impracticable.

4. If the appendages are removed for the purpose of establishing an artificial menopause and for the purpose of reducing small fibroids by modifying their nutrition, make sure to include in the ligature the main channel of the ovarian artery.

5. Vaginal ligation of the base of the broad ligament for fibroid of the uterus is an operation still on trial. As far as we have history of cases to back the theories of the operation it has stood the test.

6. Vaginal ligation of the broad ligament is a minor operation from the standpoint of mortality, and it is a minor operation from the standpoint of immediate and remote shock to the patient. It can be performed on any patient without risk, in almost any condition of physical prostration or weakness, as long as she is capable of taking an anesthetic.

7. The operation is prompt in saving blood. It succeeds in cutting off one-third more blood to the uterus than does the Bartley-Tait operation. Theoretically and practically it immediately checks uterine hemorrhages, and at once begins the diminishing of the myoma by depriving it of its nourishment.

8. The operation of ligation of the broad ligament does not leave an abdominal scar, does not unsex the woman, as does hysterectomy and the Bartley-Tait operation.

9. There are no good reasons why ligation of the broad ligament should not be an early procedure in all conditions of uncomplicated fibroids of the uterus in which the operation is practicable, even though in a few cases, subsequently, a more radical operation might be necessary.

10. The operation of vaginal ligation of the broad ligament is practicable in all interstitial or moderately subperitoneal fibroids in which it is possible by careful dissection to expose the base of the broad ligament high enough to include in a ligature the uterine artery and its branches.

YELLOW fever still continues to be prevalent in South America.

MEDICAL PROGRESS.

THE VALUE OF HEGAR'S SIGN OF PREGNANCY.—Dr. J. W. Long, of Richmond, Va., in writing in the *Buffalo Medical and Surgical Journal*, of the diagnostic points between pregnancy and abdominal tumors, speaks of the late development of the so-called certain signs of pregnancy, and gives a résumé of ten cases showing the value of Hegar's sign of pregnancy in the early months, with the following conclusions:

1. That between the second and fifth months Hegar's sign of pregnancy is one of great value, its presence always indicating pregnancy.

2. It is applicable to any case where the abdominal walls are thin and flaccid enough to grasp the uterus between the two hands, as detailed above.

3. Fibroid tumors are the most misleading complication.

4. Anesthesia is often necessary.

* * *

RUPTURE OF THE UTERUS.—Dr. Charles M. Green, of Boston, in discussing in the *American Journal of Obstetrics* the palliative *versus* the surgical treatment of rupture of the uterus, reports a number of cases and concludes that for purposes of treatment we may divide rupture of the uterus into three classes:

1. Complete or incomplete tears of the lateral or posterior walls of the lower segment, with adequate provision for vaginal drainage, with hemorrhage absent or easily controlled, and with no intestinal hernia; such cases will do well under simple palliation, with natural vaginal drainage, local antisepsis, general supportive treatment, and measures to promote and maintain firm contraction of the uterus.

2. Complete tears of the lower segment, or even moderate tears of the uterine body, with hemorrhage controllable *per vaginam* with gauze pressure or partial suture, where the child has partially passed through the rent, and where more or less blood clot and liquor amnii, and perhaps also the placenta, have entered the peritoneal cavity; for this class of cases peritoneal irrigation with weak antiseptics or sterilized salt solution,

drainage with iodoform wicking or gauze, combined with general palliative measures, would seem most appropriate.

3. Cases in which delivery of the child through the pelvis is impossible or inexpedient; in which there is present hemorrhage uncontrollable *per vaginam;* in which the rents in the uterus are extensive, and of irregular, transverse, or ragged character: for such cases abdominal section is indicated. The propriety of suturing the rents must be decided according to the condition of the uterus and the edges of the tears; when the latter are very ragged and infiltrated with blood, when the uterus is friable and apparently septic, hysterectomy promises better results than suture.

* * *

Infantile Therapeutics. — Luzet (*British Medical Journal*) gives a critical review based on the work of Legendre and Broca. The special points really consist in the phases of development in the infant, in the special feature of disease which here proceeds rapidly towards aggravation or recovery, and in the physiological peculiarities of more active metabolism, of more rapid absorption and circulation, of intact emunctories, and of a more impressionable nervous system. In regard to feeding, the regular increase in weight must be relied upon. A tuberculous nurse must not be employed, for if bacilli do not pass out with the milk, toxins can; in addition, the milk is less rich in fat and casein. Overfeeding the nurse must be avoided. Of course, artificial feeding is only a method of necessity. The milk should be sterilized by means of steam under pressure. The therapeutical bath is used to reduce temperature. The bath is then gradually cooled down from 2° below the child's temperature to 30°; it is useful in enteric fever, severe scarlet fever, and cerebral rheumatism. The bath with increasing temperature is of value in collapse such as occurs in diarrhea. It may also be a vehicle for certain medicaments. More strictly therapeutical measures are then discussed in the following order: (1) Evacuating medication. The stomach tube is very useful, as well as intestinal injections and emetics. Apomorphine is dangerous. (2) Promotion of excretions. The best diuretic is water. Large rectal injections of cold water constitute a good method of inducing diuresis. In uremia, icterus, and all intoxications large injections are useful. Cold baths are also of service in increasing renal excretion. Digitalis is well borne by children. Diaphoresis is best obtained by physical agents, heat, wet sheet, hot drinks. Diuresis is more efficient than diaphoresis. (3) Sleep should never be interrupted in disease, with very few exceptions. It may at times be necessary to induce sleep. This may sometimes be done by removing something which interferes with sleep. Physical agents are again the best means, such as tepid baths, etc. Opium requires caution; chloral is useful. Bromides and antipyrin may be of service. (4) Fever is controlled by external agents, baths, etc. Quinine, antipyrin, sodium salicylate may be useful adjuvants. (5) Food is the best tonic. Alcohol is the best stimulant. (6) Antiseptic medication plays a very important part in infantile therapeutics. Carbolic acid in any form must be avoided. The mouth should be cleansed with alkaline lotions. Glycerine is a good non-fermentable medium. Antisepsis of the stomach may be procured by washing it out, and, together with the intestine, by the use of bismuth salicylate, salol, etc. Calomel is a powerful intestinal antiseptic. Antisepsis of the large intestine is obtained by means of irrigations containing naphthol, etc. It is indicated in typhlitis, appendicitis, membranous colitis, etc.

* * *

Another Epidemic Skin Disease.— At the meeting of the Dermatological Society of Great Britain (*London Lancet*) on the 14th inst. Dr. Savill showed eleven cases of dermatitis which had attacked nearly 500 children in a day school where the average daily attendance was about 1000. It was thought by their teachers to be ringworm of the face, and they were taken to a neighboring hospital for such, but it was shown not to be ringworm because the scalp had not been attacked by the disease in

any case, and no characteristic spores or mycelium could be found after careful search. Moreover, the disease resembled a dry eczema occurring in patches, not healing in the center as ringworm does, nor had they the raised border. They were chiefly on the face, though some of the children had patches on the arms and legs. In the discussion which followed, Dr. Stephen Mackenzie regarded the condition as a common and comparatively trivial affection; but Dr. Savill pointed out, in reply, that the cases of these children very closely resembled the youngest of the cases with the epidemic skin disease described in 1891. Many of the cases of this disease he had subsequently seen (such as those at the Bethnal Green Workhouse in 1893) had been very much milder than the 1891 cases; and it would be a matter for subsequent inquiry and research whether the cases of these school children belonged to the same category or not. At any rate, there seemed evidence to show that the disease, whatever it might be, was a contagious one, spreading as it had done so extensively in this school among children who, when not at school, must live under such varying conditions of environment that it would be hard to find a local cause in operation common to them all.

* * *

General Paralysis of the Insane at Puberty.—Saiki (*British Medical Journal*), adds a case of his own to the already recorded cases in literature (12-14) of progressive paralysis of the insane occurring at puberty and adolescence. The patient was a girl aged fourteen, who seemed apparently healthy till two years before, when she had an "eruption and enlarged glands," which subsequently subsided. It was then noticed at school that she was morose and backward, and a year ago some speech disturbance began to be noticed. Both speech and handwriting became subsequently very confused and defective, and during the last three months the mental disturbance was pronounced. The pupils were unequal, fixed, reacting neither to light nor accommodation, and the whole complex of symptoms pointed to general paralysis. Direct syphilis could not be ascertained, though the author states that a prominent place as a cause should be assigned to hereditary syphilis, and predisposition in these cases.

* * *

Nævi and Maternal Impressions.—Since the days when a certain historic progenitor made large capital out of peeled saplings and probably from an even remoter age than his, there has existed, says the *London Lancet*, among mankind a belief in the causation of birth-marks by previous maternal impression. A singular illustration of this fact is to be found in a case lately recorded by one of the American papers. The mother, an Italian, while pregnant was frightened by seeing a snake among some fruit she was handling. In due time her child was born, and from birth displayed a peculiar mark upon the neck. This gradually assumed the form and appearance of a serpent, was deeply pigmented, and somewhat scaly. The tale is, indeed, a strange one. Had it come through any less reliable channel than a publication of the Transatlantic press we should probably have dismissed without question its pretentions to veracity. As it is we cannot resist the impression that facts and appearances must have been much exaggerated and altered since the original facts of evidence went on the ever-widening circuit of rumor. Nævi, it is well-known, may occupy any part of the surface of the body, may vary indefinitely in shape, are usually pigmented, and frequently possess a thickened and rough integument. In view of these facts it is difficult, even with the aid of a description almost circumstantial enough to find the mimic snake its place among the Reptilia, to resist a conviction that imagination has done much in this history to give color and shape to a clinical curiosity. The whole theory of maternal impression, however appropriate, beautiful, or strange, partakes of a character too nearly related to allegory to secure for its revelations a place among the accredited discoveries of science.

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See also Publishers' Department, Page 276

BALTIMORE, JULY 21, 1894.

The Plague in China.

That filth and dirt are important factors in the causation of many diseases is shown by the recent outbreak of the plague or "black death," as it was once called, in Canton and Hong Kong, China. From the beginning of the scourge a few weeks ago up to June 14, 1708 deaths had occurred and these were principally among the natives.

The black death appeared for the first time in England in the fourteenth century, during the reign of Edward III. It originated in the East, as did the present outbreak, and spread rapidly over the European and Asiatic continents. Its contagiousness was so great that a moment's exposure was enough to cause sickness and death. In many respects it resembles virulent typhoid fever. Animals died from it in large numbers and thousands of rats were found dead in the streets.

The symptoms described at the time were swelling and carbuncles in the armpits and groin, gangrenous inflammations of the throat and violent pains in the chest, and this is much like the present attack in China, in which there is high continued fever, accompanied by stupor, from the second to the fourth day, or in the severe cases even earlier. The characteristic swellings appear in the armpits, neck and groins; the patient rapidly becomes comatose and dies in from twenty-four to forty-eight hours. The fine flea-bite-like eruption that appears over the body, and that turns dark as the fatal end approaches, has given the name of black death to the disease. The plague prevails most in the narrow streets and in the dark and unventilated parts of the city.

Kitasato, a pupil of Koch, and who is professor of bacteriology at the University of Tokio, claims to have isolated the bacillus of this disease. The government officials are using every endeavor to stamp out the plague and it is possible that later reports will show a decline, partly from attempts at cleanliness and partly because all susceptible material will have been exhausted.

That this plague should appear after so long an interval shows clearly that the organism is very resistant and in some place has never become extinct, but has found excellent culture mediums for its growth and propagation. Should the East ever become as enlightened as the West, speaking from a European standpoint, all such filth diseases will be effectually stamped out and the plague or black death will be forever a matter of history.

* * *

Pleasant Medication.

The physician who knows how to give medicine in a palatable and pleasant form will very likely make greater headway in the affections of a family and also in many cases will cure the disease and be sent for again. Some wit has said that doctors make one great mistake in practicing medicine: they look after the disease and forget the patient, whereas they ought to keep the patient first in mind and the disease will take care of itself.

However mirth-producing that statement may be, it certainly has an element of truth in it and Dr. Magruder Muncaster, of Washington, in an article on Pleasant Medication, read before the Medical Society of the District of Columbia and reported in the *New York Medical Journal*, after apologizing for bringing before the society a subject which is not

strictly scientific, quotes Solomon, who said, "A merry heart doeth good like a medicine."

Medicine may may be just as efficient when it is pleasant to take as when it is nauseous and fortunately most persons are beginning to appreciate this. In the use of small divided doses, physicians have been able to make great progress in treating children who willingly take anything that looks like candy. This great change in the form and manner of administering drugs is undoubtedly due to improved methods of the pharmacist and also to a set of so-called homœopathists who pretend that small palatable doses and homœopathy are synonymous.

Many medicines have to be taken in a liquid form and most of them are more easily assimilated when fluid, and when it is necessary to give medicine in this way it may be well to consult the tastes of the patient, as some persons like anything sweet, while to others a bitter substance is more pleasing. It is a peculiarity of the African race in many large cities and even of the lower class of any nationality, to believe that the nastier the dose is the more effective it is, and in this class, too, it is always advisable to begin with an enormous purgative, which seems especially dear to the heart of the negro.

It is a sad but true fact, as Dr. Muncaster has said, that those who seek the services of a physician at the present day and go to a young doctor, which they do sometimes, consider his habits, manners, general appearance, and most of all the character of his medicines—that is, his ability to prescribe scientifically and palatably. The older a physician grows, the fewer drugs he uses and he almost always glides into a rut and gets into the habit of pinning his faith on one or two drugs which in his eyes are specifics. Younger men can try to avoid this and while it is just as well to employ simplicity in prescribing, still it should never be forgotten that the principal object of giving medicines is to heal and all other things are subsidiary to this.

It is right, too, to look carefully into the merits of the principal new pharmaceutical preparations that are put on the market, for some of them undoubtedly have merit. Palatable medicines are the rule nowadays and this the young and the old as well must remember. The era of pleasant medication has come and no man can oppose it.

The transferred meaning of a word may be used so often that its original definition will be forgotten. The word "melancholy" means literally "black bile" and the ancients so named it because they saw a connection between the emotions and the flow of the bile. Few persons think of the relations of the emotions to digestion and the so-called attacks of biliousness. But careful observers have seen both in adults and children a typical attack of biliousness after a violent outburst of temper. A French writer has recently reported three cases in which jaundice supervened in children of nervous temperament shortly after emotional excitement. In one case it came after a fright and in others after a fit of anger caused by punishment at school. In addition to the icteric tint, the symptoms were loss of appetite and light-colored stools The appetite was quickly regained and no other symptoms referable to the digestive system were noticed. In two cases recovery was rapid and appeared to be hastened by a dose of calomel.

* * *

The fact that a vessel from a port in South America infected with yellow fever was allowed to arrive at Baltimore without detention at quarantine is evidence of gross neglect in some direction and the way in which she was sent back to the Capes looked as if more importance was attached to the etiquette between State and national quarantine service than to the danger of infection to the city of Baltimore. The health commissioner has always been so careful of the city's interest regardless of any criticism that it scarcely looks as if he were to blame. It is very evident that there is no great difficulty in passing through quarantine.

* * *

In spite of the new medical journals that appear from time to time the number of them remains about the same, for many drop out of the race and cease to live. Whether this is the survival of the fittest is not always certain. It is, however, certain that the present hard times are felt by many medical journals and the fact that so many continue to live and even that new ones are born in these troublesome times, shows great faith in expected support and reliance on the profession for help.

MEDICAL ITEMS.

Four deaths from cholera in Paris have been reported.

Dr. Nicholas Senn is preparing a text-book on the subject of tumors.

Dr. C. Hampson Jones has removed his office to 211 West Franklin Street.

The city health department of Montreal, Canada, has established a steam disinfector.

A biography of the late Sir Andrew Clark is to be written, with a preface by Mr. Gladstone.

The *New York Journal of Gynecology and Obstetrics* will after this be published under a less local name.

Dr. E. C. Seguin, of New York City, has been elected a corresponding member of the Académie de Médecine of Paris.

Dr. J. B. S. Holmes has been elected Assistant Professor of Obstetrics and Gynecology in the Southern Medical College.

The *Southern Medical Review* is the name of a new monthly medical journal, published in Houston, Texas. Dr. N. J. Phenix is the editor.

Dr. Karl Posner, one of the responsible editors of the *Berliner klinische Wochenschrift*, has been appointed Professor of Internal Medicine in the University of Berlin.

Dr. William Christian has been elected to the Chair of Anatomy and Dr. J. Staige Davis Adjunct Professor of Pathology and Hygiene, in the Medical Department of the University of Virginia.

Dr. Middleton Michel, of Charleston, S. C., died June 4, at the age of seventy-two years. Dr. Michel was a native of Charleston and graduated from the Medical College of South Carolina, and was for many years Professor of Physiology in the Medical College of South Carolina.

Dr. E. Allen Wood, of Pittsburg, died of cerebral hemorrhage, in Philadelphia, where he had gone to attend the meeting of the Pennsylvania State Medical Society. He was one of the organizers of the Western Pennsylvania Medical College, and was the first Professor of Dietetics in that institution.

The Toronto courts have recently been considering the contagiousness of consumption. A health officer requested the dismissal from school of a child suffering with phthisis, and this exercise of authority precipitated a legal contest. The judge sustained the action of the official, claiming the disease contagious.

The District of Columbia Commissioners having noticed the working of inspection of the food law, which is so efficiently enforced by the Health Commissioners of Baltimore, have asked Congress to give the District one of the same kind. Drs. Kleinschmidt, Adams and Woodward have been appointed to support the cause.

The American Association for the Advancement of Science will hold its next annual meeting in Brooklyn during August. Brooklyn citizens have raised $5,000 to defray the expense of entertaining the scientists. This sum, we believe, is nearly as much as that given by the American Government to entertain the Pan-American Medical Congress.

The Indiana State Medical Society held its forty-fifth annual meeting at Indianapolis, May 17 and 18. Four hundred members were present. The officers elected for the ensuing year were: President, Dr. E. S. Elder (since deceased), of Indianapolis; vice-president, Dr. C. S. Bond, of Richmond; secretary, Dr. F. C. Woodburn, of Indianapolis; assistant secretary, Dr. K. K. Wheelock, of Fort Wayne.

The legislature of New York has passed a bill establishing a pension fund for employes of the health department. This act provides for physicians, nurses, clerks, and other employes who have served a term of twenty years, and for the families of employes dying while in discharge of duty. The pensions will be paid from a fund created by the fines and penalties collected for violations of the city health laws, and by fees for examinations of the records.

The health officers of Michigan held their second annual conference in Ann Arbor, on June 14 and 15, under the auspices of the State Board of Health, the president, Mr. Frank Wells, in the chair. Tuberculosis was the subject considered on the first day, a general discussion being indulged, and demonstrations given in the methods of growing and staining bacilli. The second day was devoted to the consideration of typhoid fever, diphtheria and small-pox.

BOOK REVIEWS.

JOHNS HOPKINS HOSPITAL REPORTS. Vol. IV., No. 1. Report on Typhoid Fever. Contents: 1.—General Analysis and Summary of Cases. By William Osler, M. D. 2.—Treatment of Typhoid Fever. By William Osler, M. D. 3.—A Study of Fatal Cases. By William Osler, M. D. 4.—Notes on Special Features, Symptoms and Complications. By William Osler, M. D. 5.—On the Neurosis following Enteric Fever, known as "Typhoid Spine." By William Osler, M. D. 6.—Two Cases of Post-Typhoid Anemia, with Remarks on the Value of Examinations of the Blood in Typhoid Fever. By W. S. Thayer, M. D. 7.—The Urine and the Occurrence of Renal Complications in Typhoid Fever. By John Hewetson, M. D. 8.—Typhoid Fever in Baltimore. By William Osler, M. D. Baltimore: The Johns Hopkins Press.

This extensive report on typhoid fever, which is principally the work of Dr. Osler, is a very valuable contribution to our present knowledge of that insidious disease. In the summary of the 229 cases, 23 were between 5 and 15. In the treatment, Dr. Osler is a warm advocate of the Brand method and the cold bath, which he advises in spite of the great trouble and the fact that it is extremely disagreeable to many patients. On the whole he finds that the results are so good that they counteract all other objections. In studying the fatal cases he finds that most cases occur between the 15th and 25th year, and at this time is the greatest mortality. The earlier a patient takes to bed the better are the chances for recovery.

In studying the fatal cases he found death to be due to asthenia, intercurrent affections or to accidents of the lesion; and of his 22 fatal cases, there came 8 in the first class, 4 in the second and 10 in the third.

In 85 per cent. of the cases rose spots were found; in 66 per cent. the temperature was 104° and over. In one-third of the cases there was diarrhea, and of the 22 fatal cases, in 7 there was diarrhea, in 10 it was profuse and in 5 there was none. The spleen was enlarged in about three-fourths of the cases. About 7 per cent. relapsed. In 18 cases there was temperature elevation during convalescence. In three cases there was a definite malarial attack within a few months of the onset of the typhoid. There were other complications of the nervous, circulatory, respiratory and other systems, which may be passed over. In two cases Dr. Osler found a form of perispondylitis which Gibney calls "typhoid spine."

Two of the most valuable contributions to this report are the value of post-typhoid blood examinations by Dr. Thayer, and the examination of the urine in these cases by Dr. Hewetson. Dr. Hewetson found that the general physical and chemical characteristics of the urine in typhoid fever did not differ materially from those in other acute infectious diseases. Ehrlich's diazo-reaction cannot be said to be pathognomonic of typhoid fever, but it is of definite diagnostic value.

The last section, on Typhoid Fever in Baltimore, by Dr. Osler, has already been noticed editorially in these columns. Although Baltimore has not a large mortality percentage, this report shows that there are too many cases of typhoid fever occurring.

REPRINTS, ETC., RECEIVED.

The Successful Treatment of Anemia. By H. P. Loomis, M. D., New York.

Gold in Therapy. By E. A. Wood, M. D., Pittsburgh, Pa. Reprint from the *New York Medical Journal*, 1893.

Clinical Notes on Typhus Fever of Northern Mexico. By Clarence Warfield, M. D., Galveston, Texas. Reprint from *Transactions of Texas State Medical Association*, 1894.

The Uric Acid Diathesis and its Treatment. By John F. Barbour, M. A., M. D., Neurologist to the Louisville City Hospital. Reprint from the *American Therapist*, June, 1894.

Teno-Suture and Tendon Elongation and Shortening by Open Incision; Advantages and Disadvantages of the Various Methods. Clinical Lecture delivered at the Jefferson Medical College Hospital. By H. Augustus Wilson, M. D., Philadelphia. Reprint from *International Clinics*, Vol. 1, Fourth Series.

Mr. Albert Turner, who has been for nearly thirty years connected with the Fowler & Wells Company, is announced as the Manager of a new Journal of Practical Hygiene to be called "*Health*," for which well-known writers on the subject will contribute. The Announcement for July number contains the names of Dr. Oswald, Dr. C. E. Page, Dr. Dodds, Julia Colman, Hester M. Poole, Dr. W. E. Forest, Mrs. Le Favre, M. Poole, Miss E. Marguerite Lindley, Mrs. Hudders, Dr. Fuller, Helen Gilbert Ecob and others. To be issued as a quarterly at 15 cents a number, or 50 cents a year, by the Health Publishing Co., 88 Reade St., New York.

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NOTES.

CHLOROL is a new disinfectant, the basis of which is mercuric chloride.

*

AMMONIUM bromide in large doses is said to have cured severe cases of tetanus.

*

SODIUM benzoate in large doses is recommended in the treatment of inflammatory affections of the throat.

*

WHEN bismuth is indicated in diarrhea, it should be given in very large doses, from ten to sixty grains, to be effective.

*

METHYL mercaptan is the substance to which the peculiar odor of the urine after asparagus has been eaten is said to be due. It was isolated by Nercki.

*

LOSOPHAN or tri-iodometa-cresol, containing over seventy-five per cent. of iodine, is soluble in ether, benzine and chloroform. It has been recommended by Saalfeld in parasitic skin diseases, as well as in chronic eczema, prurigo and similar affections where there is no pronounced inflammatory condition. It may be used in a one to two per cent. solution, in a one to ten per cent. ointment with vaseline or four parts lanoline and one part vaseline.

READING NOTICES.

Cactina Pillets.—There is no doubt about the value of Cactina Pillets. In heart troubles, especially those of neuralgic character, weak heart, exhausted energies, some neurologies and nervous prostration, Cactina Pillets will prove curative. Joseph C. Ellis, A. M., M. D., Frankford, Philadelphia, Pa.

*

Therapeutics of Trional.—In an inaugural dissertation presented to the University of Freiburg, Dr. Otto Bakofen gives an interesting review of the extensive literature of Trional, and calls attention to the unanimity that exists in the views of authors as to the excellent properties of this remedy. The advantages of Trional consist especially in its reliability and efficacy in those conditions of sleeplessness which experience has shown it is most difficult to obtain permanent results. This applies more particularly to simple agrypnia and the insomnia of persons suffering from mental diseases or excitement due to alcohol. In cases of simple insomnia Trional has always proved effective; while favorable testimony is more and more accumulating with reference to its utility in cases of alcoholic excitement, which are known to be rebellious to the action of other hypnotics.

*

Hæmoferrum (Stearn's) is in pseudo-crystalline or semi-powdered form, of pleasant taste, agreeable odor, neutral in reaction, and very soluble, which important properties they claim entitle their product to a characteristic name, in order to distinguish it from other similar organic preparations of iron, which are of variable composition, generally unpleasant in taste and odor, and not nearly so soluble as theirs. A few of the more important advantages of Hæmoferrum (Stearn's) over other forms of iron are: (1) It is not an exosmotic, consequently does not constipate. (2) It is non-poisonous, therefore, if accidentally taken in large amounts will produce no disastrous effects. (3) Its continuous use does not affect the teeth in the least, it not being styptic. (4) Its use does not tax the digestive organs when they are in weakened condition. All those applying to Messrs. F. Stearns & Co., of Detroit, Mich., will be furnished with samples and literature free, and they request that the medical profession give their new product a thorough trial.

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ORIGINAL ARTICLES.

THE DIAGNOSTIC VALUE OF PEPTONURIA AND INDICANURIA.

Read Before the Philadelphia County Medical Society, June 13, 1894.

By John H. Musser, M. D., and F. Savary Pearce, M. D.,

Philadelphia, Pa.

The following observations have been made from time to time during the past six months by the writers in order to determine the diagnostic value of the presence of the above-mentioned constituents of urine in disease, and to observe the practicability in daily practice of the methods employed to detect their presence. It is our purpose to continue on a more extended scale the observations here begun.

The specimens of urine studied were taken mostly from the medical wards of the Presbyterian Hospital. Through the kindness of Dr. Abbott, the testing was in the main done in the Hygiene Laboratory of the University of Pennsylvania. Our appreciation of the aid of the resident physicians, Drs. Arnold, Swan, and Johnson, is hereby acknowledged.

1. Tests.—Von Jaksch[1] gives two methods for testing for peptone in the urine. The first, that of Hoffmeyer, is far too complicated and is not, therefore, detailed. The second, the "Devoto method," is given as the best, and is the one here used. The principle lies in the exclusion as far as possible of all other albumens. It is as follows: Take 200 to 300 c.c. of urine, to which add pure crystals of ammonium sulphate in proportion of 80 grammes of the sulphate to 100 c.c. of urine. This solution is placed in a beaker in a boiling-water bath for one-half an hour, when the greater part of the salt should be dissolved. It is then steamed in Budenberg's steam sterilizer for another half-hour, the vapor being kept at 100° C. By this procedure, all proteids (serum albumen, globulin, hemoglobulin, deutero-albumose, peptone, nucleo-albumen —*i. e.* mucin) areprecipitated; but the serum albumen and globulin and nucleo-albumen are thus the only *thoroughly* coagulated bodies, the hemoglobulin being only *partly* coagulated.

After this last heating to 100° C. filter at once. The filtrate should be straw-colored and free from albumen, as indicated by boiling or the potassium ferrocyanide[2] tests. A *slight* cloudiness appearing with the ferrocyanide test does not necessarily imply the presence of albumen. A *decided* turbidity or precipitate would be due to a proto-albumose, or, more probably, hetero-albumose. Should the hot filtrate be cloudy or give the proteid reactions, the investigation has miscarried and must be repeated from the beginning. The residue is washed first with *hot*, then with cold water. The resulting filtrates show a more or less decided brownish tint. These are collected, and to one portion of the fluid acetic acid and potassium

ferrocyanide solution are added to test for albumen. Should no result be obtained the biuret test is performed with a portion to which caustic soda or other alkali has been applied in excess. Any albumen shown to be present is *certainly* peptone.

The filtrate from the *hot* washings may exhibit it, but it often happens that the peptone *first becomes recognizable with the biuret test* in the filtrate derived from the *cold* washings.

Several specimens, both of the hot and cold washings, may be tested until a positive result is obtained.

The test for peptone is, therefore, at best very delicate and requires much time to work out. The biuret reaction is that by which the color test (for such it is) for the peptone is obtained, as inferred from the above. It is as follows : Urine : Add caustic potash, caustic soda, or ammonium hydrate in excess ; then add, drop by drop, solution (10 per cent.) of copper sulphate. If *albumen* be present the resulting peroxide of copper (a green precipitate) is dissolved, and the fluid assumes a *reddish-violet* color.

Peptone strikes red, not violet in the fluid. As this reaction is probably not familiar to many, the color produced is here exhibited (and in a less intense degree than it is usually found in peptonuria experimentation) by adding albumose, containing peptone, to the test.[3]

The test for indican is much more simple, and, as given by Strümpell,[4] is as follows : "We mix equal volumes of urine and officinal hydrochloric acid (P. G.), and then add, drop by drop, a concentrated solution of chloride of lime, shaking it after each drop is added. If the urine contains *much* indican, a decided indigo-blue color appears." To this may be added, that the test can be brought out more clearly, chloroform, then agitating. After standing, it will be found the chloroform at the bottom of the tube will be colored violet or bluish.

2. Origin of Peptone.—In health peptone is produced in the blood by the act of digestion. We know that the proteids ingested are transformed into peptones in the stomach and intestines. The peptone is reconverted into proteids in the circulation. Peptonization is, therefore, the *sine qua non* for absorption of proteids. In health the peptone is immediately transformed on entering the blood, hence the reason for the statement of physiologists that "peptone is not found normally in the blood or urine."

The occurrence of peptones in the blood or urine in disease would show over-production or a lessened power of the system to assimilate it.

G. Bjorkman's[5] excellent paper throws out some suggestions as to the rationale of peptonuria. He says : "If we regard the chemotactic influence upon absorbed peptones as the reason for such increase in the number of white corpuscles during digestion, many obscure mysteries in the physiological phenomena of absorption will be cleared up."

From the above statement we can infer that an excess of peptone, because the digestive and absorptive power of the white blood-cells are impaired, is carried off as waste in the urine.

The leucocytes multiply for defence in septic and other hemolytic cases, and some become pus cells, undergo degeneration and furnish increased peptone in the blood, which is then carried off in the urine.

3. Origin of Indican.—Indican is found normally in the urine in small amounts. Chemically indican is indoxysulphate of potassium and is colorless, but on adding strong acids or oxidizing agents indigo is set free, producing a blue color.

Its origin in health is hardly established.

In disease indican is likely formed from indol, a product formed in the small intestines by the decomposition of albumen and other substances under the influence of bacteria.

4. Clinical Significance of Peptonuria (*i. e., excess of Peptone*).—As before stated, peptone is not found normally in the blood or urine. It cannot, at least as yet, be detected so frequently or easily in any case as serum-albumen. Peptone is especially found in the urine, according to von Jaksch and other

authors, in septic conditions, and under all circumstances where pus is formed in the body—*e. g.*, tubercular cavities, as in the lungs, abscesses, etc.

Von Noorden, however, in his recent work, *Lehrbuch der Pathologie des Stoffwechsels* (Berlin, 1893), does not think peptone is found in the urine. On the other hand, Robitschek has recently done some experiments for von Jaksch. An abstract of their work appears in *The Practitioner* for June 4. These authors lay stress upon "*The Significance of Peptonuria.*"

5. Clinical Significance of Indicanuria (*an excess of Indican*).—Osler[6] gives, under the head of "Anomalies of the Urinary Secretion," some eighteen substances that may be found in abnormal urines. Some of these are detected in small amounts in health; others being considered always as abnormal, so far as is known to-day. He further states that indican, when in excess in the urine, often denotes "chronic constipation or ileus."

Strümpell[7] refers to the same thing, as does one of the authors.[8] Indican is also said to exist in some cases that are on a strict milk diet; in wasting diseases, especially if secondary to gastro-intestinal diseases; in peritonitis and empyema, and especially where large quantities of albuminous matter are undergoing rapid decomposition in the intestinal tract. On the contrary, in catarrhal jaundice and in cirrhosis of the liver some clinicians say it is found in very small amounts only. Indican may be thrown down before the urine is voided, but usually, when present, is found after that secretion cools outside the body.

The following observations here tabulated,[9] as to peptone, indican, albumen, and uric acid in the urine, of the total number of specimens examined are too few in number to base conclusions of a definite character. As to peptonuria and indicanuria, they support in the main the foregoing statements.

We were engaged at the time in studying the urine of cases of typhoid fever. We take this opportunity of presenting the results of the examination for peptone and indican in this disease. Thus in twenty-two experiments in twelve cases of typhoid fever, fair reactions for peptone were obtained in three cases only, while the indican test detected that substance in excess in sixteen out of the twenty-two tests.

In one of the three cases there was a large number of boils, which accounted for the peptonuria. In the other two no foci of suppuration could be found. Such focus was probably present.

Conclusions: 1. It can be said that peptonuria does not occur in typhoid fever in the natural course of the disease.

2. Its presence would point to some area of suppuration.

3. Indicanuria is common to typhoid fever, and indicates the continuance of an intestinal putrefaction. May it not be possible in cases of typhoid fever, with a febrile course continuing after the specific symptoms have subsided, to determine by this test whether the said fever is due to the persistence of intestinal lesions or to a remote process, and the absence of indicanuria, therefore, point to the removal of any intestinal complication?

The number of cases *other* than typhoid fever examined were forty-five. Many specimens were repeatedly examined as checks, making in all seventy-two tests, not including the typhoid cases.

We shall not burden you with the reading of the long tables here shown, but simply summarize the disease and findings under each head.

1. Cases with Absence of Peptone in the Urine.—There were twenty-one cases out of the forty-five cases examined in which no peptone reaction was found.

Five out of the twelve known septic cases contained no peptone in the urine. In two of these cases, of old well-draining tubercular sinuses, the pyogenic membrane probably acted as a dam, producing for practical purposes local discases, not affecting the system, as a dyscrasia.

The one appendicitis case (out of three tested) not having peptonuria was of mild type and recovered without event. There was no generalized morbid process.

Among the remaining cases where no peptone was found in the urine were

those of various diseases in the medical wards, mostly doing well, such as corneal ulcer, supposed abscess of groin (proving on operation to be a dermoid cyst), hysterical hemiplegia, septic stump (making a rapid recovery), hysterical hemiplegia, influenza, articular rheumatism (subacute), bronchitis, hysteria, chlorosis.

Cases in which No Peptone was found in the Urine:

Appendicitis	1	Neurasthenia	1
Bronchitis	1	Rheumatism (articular)	1
Bright's disease (mild)	1	Rheumatoid arthritis	1
Chlorosis	1	Sciatica	1
Catarrhal gastritis	1	Septic stump (rapid recovery)	1
Corneal ulcer	1	Septic condition of groin (proved to be dermoid cyst at operation)	1
Epilepsy	1	Tubercular bone disease	2
Hysterical hemiplegia	1		
Hemiplegia (organic)	1		
Hysteria	1		
Influenza	1		
Pleural effusion (slight)	1		
Pneumonia (mild)	1		
		Total	21

2. Cases with the Presence of Peptonuria.—All the cases in which suppuration was known to be present had peptone in the urine except two. Of the two out of three appendicitis cases that showed peptonuria, one recovered; in the other perforation took place. Operation was done, finding much pus, the patient dying of septic peritonitis.

In all of the forty-five cases (excluding the ten septic ones) peptone was found among the miscellaneous diseases (thirty-three) in twenty-four, such as Bright's disease, pneumonia, pyothorax, pulmonary tuberculosis, chronic valvular disease of the heart with extreme anæmia, pleural effusion and in such diseases where there was destruction of the *blood cells*.

Cases in which there was Peptone in the Urine:

Anemia (extreme)	1	Pleural effusion (marked)	1
Acute general dermatitis	1	Pyemic or septic cases (out of the twelve examined)	10
Appendicitis	2	Typhoid (covered with boils)	1
Bright's (chronic)	1	Tuberculosis	3
Chronic valvular heart disease with anemia	1		
Gelatinous arthritis (knee)	1		
Pneumonia (severe type)	2	Total	24

In the case of septicemia with retained secundines in which there was also marked reaction for peptone there was extreme leucocytosis, the blood estimation revealing the following: white-blood corpuscles equals 49,966 to c.mm.; red-blood corpuscles equals 3,925,000 to c.mm.; hemoglobin, 43 per cent. This is confirmatory evidence of what takes place in the blood in septic conditions. It may probably, *a priori*, be that leucocytosis is generally found to accompany peptonuria. With this cell disintegration, too, according to Victor Vaughan[10] and others, the corpuscle nuclei being destroyed furnishes xanthin and uric acid in excess in the urine.

3. Cases in which there was Little or No Indican in the Urine.—Out of forty-five cases of miscellaneous diseases (thus still excluding the twelve typhoids already classified) formulations of the findings is as follows:

a. In thirteen diseases, including epilepsy, Bright's disease, hemiplegia, pneumonia, tuberculosis, and rheumatoid arthritis, indican was entirely absent or only the faintest blue color was produced which was then assumed as physiological.

Cases in which there was Little or No Indican in the Urine:

Of the pyemic cases, 4:	Abscess (buttock)	1
	Infected wound	1
	Tubercular bone disease	2
Miscellaneous, 13:	Amputated stump	1
	Arthritis (rheumatoid)	2
	Arthritis (gelatinous)	1
	Bright's disease	2
	Corneal ulcer	1
	Epilepsy	1
	Hysteria	1
	Pneumonia	1
	Neurasthenia	1
	Tuberculosis, lungs (incipient)	2
	Total	17

4. Cases in which Indican was Present in Very Appreciable to Marked Amounts in the Urine.—We found indican in twenty-five of the forty-five cases examined (excluding again the typhoids).

In general the diseases included pleural effusion with intestinal catarrh, catarrhal gastritis, nervous dyspepsia, and all three appendicitis cases from a good to marked reaction.

Indican was also found in excess in the case of cancer of the uterus. When thus found in the urine in local cancer, indican may be of value as showing secondary nodules in the intestines, or at least deficient and altered functionation produced by the malignant disease.

Indican was also found in the urine of the case of septicemia from retained secundines. Here the close proximity of the focus of pus to the intestinal tract most likely was the cause of the fermentation in the gut.

We were unable to obtain any cases of

intestinal obstruction for examination during the time of making these studies.

Cases with Indican present in Excess in the Urine:

Abscess (psoas and lumbar near intestinal tract)	3
Appendicitis	3
Acute dermatitis (bowels torpid)	1
Anemia (extreme) with constipation	1
Articular rheumatism	1
Chronic valvular heart disease with subacute intestinal catarrh	1
Chlorosis (with constipation)	1
Cancer, uterus	1
Catarrhal gastritis	1
Dermoid cyst	1
Hysterical hemiplegia	1
Hysteria, anemia, and constipation	1
Hemiplegia (organic) with constipation	1
Influenza	1
Pneumonia	2
Pleural effusion	1
Retained secundines with intestinal torpor	1
Sciatica	1
Tuberculosis	1
Typhoid (covered with boils and hence included in pyemic cases)	1
Total	25

5. Association of Peptonuria with Indicanuria.—The two were found together in a large number of the cases in which either compound was detected.

Peptone occurred, as stated, in the large majority of septic cases.[11]

Where there was extreme emaciation with intestinal symptoms as an especially prominent etiological factor, indican was found in the urine in excess.

The relation of indicanuria with peptonuria depends on two things mainly:

a. If the septic or other irritating condition is localized in the gastro-intestinal tract marked indicanuria is detected.

b. If the general system becomes involved in the albuminous compounds, destruction, then peptone is formed in excess in the blood and hence thrown down in the urine along with the excess of indican.

Peptone depends on changes really in the system.

Indican depends on fermentation really outside of the body (*in the gut*).

Thus depending on *general* cell destruction and elimination of the suboxidized proteid product, or on *local* intestinal fermentation being prominent, will peptone or indican be found in excess in the urine.

If the *local* and systematic conditions exist together as described, then we may expect to find both products in the urine. Then, too, the indication is of more serious disease.

6. Association of Albumen with Peptonuria and Indicanuria.—In the specimens of urine in which albumen was found, it was due to a definite cause, as in Bright's disease or pyuria, hence in these experiments albuminuria bore no relation to peptonuria or indicanuria.

7. Likewise there is negative result in these few experiments in comparing the frequency of excess of uric acid with excess of peptone or excess of indican in the urine. The long-accepted theory of direct relation between uric acid and urea is now overthrown.

It would be, therefore, of value to test more extendedly for the relation of uric acid (known now to be produced from cell nuclei destruction) to peptonuria and leucocytosis. A great field is open here.

Finally, the trouble and time taken to do this work thus far proves it not to be very practical.

But if one *had* the opportunity and time for such investigation of cases important indications would undoubtedly be derived.

REFERENCES.

1. Clinical Diagnosis, p. 255.
2. This test is as follows: Urine is filtered and then acidulated with acetic acid. Then add a few drops of a 10 per cent. solution of potassium ferrocyanide. If the urine becomes turbid it shows the presence of albumen.
3. Showed test-tube with reaction.
4. A text book of Medicine, p. 408.
5. "The Physiological Role Played by the Leucocytes," American Medico-Surgical Bulletin for January, 1894.
6. The Principles and Practice of Medicine, pp. 772 to 737.
7. A Text-book of Medicine, p. 408.
8. Medical Diagnosis, p. 331.
9. Showed detail tables as to peptone, indican, albumen and uric acid findings in — I. Typhoid fever cases (12). II. Miscellaneous diseases (33). III. Known septic cases (12).
10. "Nuclein and Nuclein Therapy." Journal of the American Medical Association for June, 1894.
11. The liability to inaccuracies in the work of *creeping in* must be considered in excluding peptonuria from two septic cases.

The Fats of Human Milk.—Ruppel (*British Medical Journal*) has made a very careful analysis of the fatty constituents of woman's milk. The task is not easy, and he admits that there is extreme difficulty in eliminating the higher acids. He concludes that human milk is relatively poor in volatile fatty acids. The fixed oils consist of nearly 50 per cent. of oleic acid. Of the fixed solid oils, myristolic and palmitolic prevail over stearoleic acid.

A SERIES OF TWENTY-FIVE ABDOMINAL SECTIONS.

THE THIRD SERIES OF MY SECOND HUNDRED CASES.*

By I. S. Stone, M. D.,
Washington, D. C.

This series includes all sections from October 3, until January 10, 1894.

In this series three deaths have occurred. The first, No. LXV, was due to hemorrhage from suture tracts in a "bleeder."

The second due to bowel obstruction following oöphorectomy in a pelvis bound fibroid. The third was due to shock and suppression of urine in a case of hysterectomy by the so-called "Pratt method."

In the "pus operations," eleven in number, all recovered. Two deaths thus far in pus cases in the seventy-five cases thus far reported. Several of these cases were brought in on stretchers and were life-saving operations.

Case LI. Mrs. J. Intra-mural fibroid of uterus. Removal of double pyosalpinx. Abscess of ovary. Perfect recovery.

Case LII. March. Cystic ovary. Severe menorrhagia. Patient had floating spleen. Ovarian cyst, 2 oz. A perfect cure.

Case LIII. Mrs. L. Double oöphorectomy. Pelvic peritonitis and salpingitis. Prompt recovery.

Case LIV. October 19. Nephrectomy for hydronephrosis. Miss C., age 16. Abdomen distended by what appeared to be an ovarian tumor. The right kidney had become distended into thin walled cyst—seven pounds.

A calculus was found in the ureter just below the pelvis of the kidney. Time, thirty-seven minutes.

Specimen in Museum of the Surgeon General's Office. Perfect recovery. Patient returned to her home in three weeks. (Vide *International Medical Magazine* for March, 1894.)

Case LV. October 21. Salpingo-oöphorectomy. Mrs. A. Uterus tied backward by results of former pelvic peritonitis. Old salpingitis and hydrosalpinx. Uterus raised to normal position. This patient had been a victim of hysteria for years. Her recovery has been entirely satisfactory in every way.

Case LVI. October 25. Double salpingo-oöphorectomy for pus. Mrs. A. This patient had uterus curetted. Cervix repaired and laparotomy done at one sitting, the whole occupying thirty-four minutes. Recovery.

Case LVII. October 25. Hysterorrhaphy. Mrs. P., age 46. Left cystic ovary removed. Buried silk-worm gut to secure the uterus to the abdominal wall. Operation required fifteen minutes. Recovery.

Case LVIII. October 29. Old sinus. Mrs. R. This is the fourth operation upon this patient. The first was done by another surgeon, who removed a myoma uteri. The wire clamp caught a loop of bowel. A fecal fistula resulted.

My first attempt was to close the fistula by cutting down upon the bowel and closing it.

This attempt failed because the tract of the sinus from the pedicle reinfected the sutures, with the result that the wound opened again in two months. I then removed the stump of the tumor, *i. e.*, the uterus, by vaginal method.

Finally the last operation was done successfully. The patient has had no further trouble with the sinus, and has the appearance of perfect health.

Case LIX. October 31. Oöphorectomy. One cystic ovary removed. Miss N. Uterus secured in anteflexion. Operation, fifteen minutes. Recovery.

Case LX. November 4. Double pelvic abscess. Miss L. Very difficult operation. Great difficulty in finding the uterus and appendages. Everything fused together in indistinguishable mass.

* For other cases see *Virginia Medical Monthly*, March and May, 1894.

Intestines injured. Ovaries not much involved, the disease having extended from the Fallopian tubes.

The intestines themselves furnished a portion of the abscess wall. Operation, one hour. Good recovery.

Case LXI. November 8. Double salpingo-oöphorectomy for pus. Mrs. B. Prompt recovery. Time, thirty-eight minutes.

Case LXII. November 11. Salpingo-oöphorectomy for pyosalpingitis. Miss P. Recovery. Time, eighteen minutes.

Case LXIII. November 11. Suspected tubercular peritonitis. Miss H. Encysted peritoneal dropsy. Opened two separate sacs, one on level with umbilicus, with pus present.

The other in pelvis with serum. Drained both cavities from above. Gauze drain through vagina.

This patient was a forlorn, hopeless case. She made quite an unexpected and satisfactory recovery. Time, thirty minutes.

Case LXIV. November 15. Hysterectomy. Mrs. H. Large, soft myoma. When first removed, fifteen pounds. Operation completed in forty-five minutes. Baer's method. Recovery. (Vide *Annals of Gynecology*, April, 1894.)

Case LXV. November 18. Exploratory laporotomy. Miss B. This patient had four operations for her symptoms, the last proving fatal, due to hemorrhage from suture tracts.

The first operation was done by myself for salpingitis. While still in the hospital she had a severe hemorrhage, apparently without cause, from vagina, and also into the abdomen.

A colleague who operated in my absence states that he discovered an opening through the vagina, near the cervix, communicating with the pelvic cavity.

This was closed and the patient went home but continued to have hemorrhages from the uterus, for the cure of which I removed the uterus. The uterus was pronounced sarcomatous by Dr. W. B. Gray, of the Army Medical Museum.

Many months after this the patient returned, complaining of severe pain in the pelvis, and after much delay the last operation was done to ascertain its cause.

Only a remnant of one ovary could be found. The pelvis was in perfectly satisfactory condition.

After the operation she appeared to suffer from shock. All efforts failed to save the patient, and at the autopsy everyone was astonished to find her death due to a considerable hemorrhage from the suture tracts.

Case LXVI. November 20. Appendicitis. Mr. A. Patient had suffered many previous attacks. Appendix found buried amidst coils of intestine. Perfect recovery.

Case LXVII. November 22. Hysterorrhaphy. Mrs. H. Patient had retroflexion, due to pelvic peritonitis, which followed an abortion.

Adhesions were separated, the uterus elevated and secured to the abdominal wall. The appendages were not removed. Recovery.

Case LXVIII. November 25. Pelvic suppuration. Mrs. M. Pelvis filled with mass made up of pus sacs, intestines, etc. Patient in extremis. Right tube and left tube and ovary removed.

Drainage through vagina by gauze and rubber tube. Thorough drainage saved this patient. Operation, forty-five minutes. Pulse was very quick, but patient made good recovery after shock passed away. Time, forty-three minutes.

Case LXIX. December 9. Salpingitis. Miss C. Both appendages removed. Cystic ovaries. Easy operation. Eighteen minutes. Quick recovery.

Case LXX. December 20. Hysterectomy. Mrs. F. Myoma filling the entire abdomen. Ten pounds, twelve ounces. Recovery. Time, one hour. Baer's operation. (Vide *Annals of Gynecology*, April, 1894.)

Case LXXI. December 16. Uterine arteries ligated. Mrs. S. Fibroma filling pelvis. Abdomen opened and right ovarian vessels tied. The left vessels were immense sinus and could not be safely tied. At the same sitting the lower uterine arteries were tied as practiced by Dr. F. H. Martin, of Chicago. Sufficient time has not yet elapsed to decide the question of reduction in size. Time, forty-two minutes.

Case LXXII. December 23. Sal-

pingo-oöphorectomy for fibroid. Tumor filling the pelvis and pressing upon the rectum.

Death from obstruction in forty-two hours. Should have removed tumor instead of the minor operation.

Case LXXIII. December 26. Extra-uterine pregnancy. Mrs. D. Rupture of tube seven weeks after last menstruation.

Large quantity of blood in the abdomen. Time, fifteen minutes. Prompt recovery.

Case LXXIV. January 3, 1894. Vaginal hysterectomy. Mrs. M. Patient had extreme anemia. Exterpation of the uterus by the so-called Pratt method. Much oozing. Ether anesthesia.

Complete suppression of urine during the twenty hours the patient survived the operation.

Case LXXV. January 10. Papilloma ovariana. Mrs. K. Exploratory laparotomy. Cysts could not be removed.

Patient recovered from operation, and is still living. Requires occasional tapping for ascites.

Early Operations in Malignant Growths.—Malignant growths should be operated on early and thoroughly in order to be radically removed. Dr. R. A. McLean, in the *Journal of the American Medical Association*, points out that one cause of failure is the large development of the growth when the surgeon is first consulted. Ulceration has commenced and the exhausting effects of the discharge added to septicemia give little chance for success. This is often the fault of the family physician, who has been using various local methods instead of calling in the surgeon at once. Very often the doubt lies between syphilis and malignancy when a course of specific treatment could settle the question promptly, and even if the growth is tuberculous, extirpation is the only proper treatment. In support of the statements the following propositions are offered:

1. All cases of suspected malignant growths should be treated surgically in the early stages of their development according to the rules of procedure above outlined.

2. Excision should be done in all cases of malignant growths, however extensive, in which the general health has not been seriously impaired, or extensive lymphatic involvement or metastases have not occurred.

3. Operation should be refused in cases of recurrent or primary malignancy, in which the general health is so much impaired as to render an extensive operation a serious risk to life; in all cases of extensive ulceration and infiltration of lymph vessels and glands; and in all cases of sarcoma in which there is a probability of metastasis having already occurred.

* * *

A Case of Bulbar Palsy.—Dr. Alfred Wiener, in studying a case of subacute unilateral bulbar palsy, in the *New York Medical Journal*, carefully examines each symptom presented, and as the result of his observation on each anatomical lesion he concludes:

1. That the region of the hypoglossal nucleus gives origin to nerve fibers which supply the tongue, palate, pharynx and larynx on one side of the body.

2. That the column of nerve fibers known as the respiratory bundle consists of fibers from the glosso-pharyngeal, vagus and vago-accessorius nerves, and that the lower and outer portion of this column probably serves as the locality for the vagus and vago-accessorius fibers.

3. That the glosso-pharyngeal nerve seems to control the reflexes of nausea and gagging in the soft palate and pharynx, and also to send some of the motor filaments to the pharyngeal muscles. These latter filaments take their origin in the hypoglossal nucleus and ascend in the respiratory column to the nucleus proper, and then make their exit with the glosso-pharyngeal nerve.

4. That the soft palate muscles are not innervated by fibers from the seventh nerve.

SOCIETY REPORTS.

THE AMERICAN MEDICAL ASSOCIATION.

FORTY-FIFTH ANNUAL MEETING, HELD IN SAN FRANCISCO, CALIFORNIA, JUNE 5, 6, 7 AND 8, 1894.

Specially reported for the MARYLAND MEDICAL JOURNAL.

SECOND DAY, JUNE 6, 1894.

SECTION ON GYNECOLOGY AND OBSTETRICS.

THE subject of PLACENTA PREVIA consumed the entire forenoon. Dr. Llewellyn Eliot, of Washington, D. C., presented the subject in an able manner to a very interested audience, as the time consumed in discussion after the reading of the paper proved. Some of the various methods of management were approved and others emphatically rejected. On the whole it was one of the liveliest and one of the most interesting of all the sessions of this section.

Dr. J. M. Duff, Pittsburg, in his paper upon SOME OF THE USES OF STRYCHNINE IN OBSTETRIC PRACTICE, said that this drug judiciously used was most efficient in toning up the uterine muscles and rendering the indications for instrumental delivery very much less frequent. It improves the appetite, lessens insomnia, ensures a shorter and less painful delivery and lessens the after-pains. If an anesthetic is needed there is less danger than if there had been no previous preparation by the use of strychnine. Its action is much more prompt than that of ergot. In discussing the paper Dr. Lapthorne Smith, of Montreal, said that for ten years he had been using strychnine, phosphoric acid and iron for some time previous to delivery and had never had a post-partum hemorrhage. Dr. Carpenter, of Pennsylvania, has found strychnine so valuable in antagonizing the dangerous effects of anesthetics that he gives it for one month preceding delivery.

Dr. Martin, of Chicago, approved of the use of this drug for the reason that it produced tonic instead of clonic contractions of striped and unstriped muscle fibers, and also had a powerful effect as a central tonic. Pain is caused by a clonic spasm. True contractions are without pain. Hence, strychnine in large doses proves to be a powerful anodyne.

Dr. Winterberg, of San Francisco, presented the subject of SYMPHYSIOTOMY in a very scholarly and exhaustive paper. He preferred this operation in every case to Cesarian section where there is sufficient mobility of the sacro-iliac synchondroses and the contraction of the inferior straits not too great.

Dr. Holmes, of Oregon, the first on the Pacific slope to perform the operation, was enthusiastic in its praises.

Dr. Beverly Cole, of San Francisco, thought there was less danger of sepsis in Cesarian section. He further objected to symphysiotomy on the grounds of danger of non-union of the symphysis and consequent unsightly gait.

Dr. W. F. McNutt, San Francisco, related a case occurring in his practice of AN ABDOMINAL PREGNANCY COMPLICATED WITH FIBROID TUMOR OF THE UTERUS. The woman, during the time she was carrying the child, complained of very few abnormal symptoms. At full time she suddenly had a sense of something giving way, and at once a large amount of water was discharged in the bed in which she lay. The physician summoned shortly afterwards found the patient delirious. The bed was wet, but the source of the water could not be determined—whether it was amniotic fluid or urine. A hypodermic of morphia was given, and the further course of labor awaited. But the next morning the woman was still delirious, and there had been no change in the condition otherwise. The speaker was then summoned in consultation. On examination by the vagina, he found a long cervix not at all dilated. The child was distinctly to be made out through the abdominal wall—so plainly that he thought first of rupture of the uterus; but the pulse and general condition precluded that possibility. Not being quite clear as to the diagnosis, the speaker decided to wait and make another examination before acting.

Being unable to return to the case at the time set, he asked Dr. Winslow Anderson to go in his place. Dr. Anderson, on examining by the rectum, found in addition to the child a tumor occupying the neck and lower part of the body of the uterus. As this was sufficient to obstruct delivery, it was decided at a subsequent consultation to open the abdomen. This was accordingly done by the speaker. At once he came upon the child lying outside the uterus, among the intestines. No membranes surrounded it, and there was no amniotic fluid in the peritoneal cavity. The cord was ligated and the child delivered. The placenta was attached to the right corner of the uterus, the right broad ligament and then to the abdominal peritoneum, nearly as high as the liver. There was a great hemorrhage following its release and removal, but this was soon checked by tying of the broad ligament in the subsequent hysterectomy. This latter was performed at once after removal of the child, on account of the fibroid tumor, in the usual manner for abdominal hysterectomy. The patient died two days afterwards, never having recovered from her delirium. This was her second child, the first being born seventeen years before. The child was alive when born, but breathed very slowly and its heart's action was also slow. It lived but a few hours. Examination of the right broad ligament showed it was much enlarged and thickened, but there was no sac and no evidence of rupture, from the ligament into the peritoneal cavity. The tubes and ovaries were both intact. There was no elongation of the right tube; its fimbriated end was free and quite patent. There was nothing, in fact, to speak against abdominal pregnancy, except the absence of fetal membranes. These were nowhere found.

Dr. H. R. Holmes, of Oregon, read a paper on SUSPENSION OF THE UTERUS IN EXTREME ANTERIOR DISPLACEMENTS. Following out the line of procedure for ventral fixation in retro-displacements, he gave the results in six cases where the uterus had been stitched to the abdominal wall one and one-half inches above the pubes for the correction of extreme anteversion and antiflexion, the results being most satisfactory.

Dr. Henry Parker Newman, of Chicago, in the course of his paper on A PLEA FOR THE MORE THOROUGH TRAINING IN OBSTETRICS AND GENERAL MEDICINE ON THE PART OF THE GYNECOLOGIST, said that the cloud on the horizon of medicine was the growing tendency of graduates to enter at once upon a specialty. No specialist should be trusted who had not had a wide and varied experience as a physician and surgeon.

Dr. Eastman agreed with Dr. Newman that the specialist should be a physician and surgeon and something more.

THIRD DAY, JUNE 7.

Dr. Eastman in the chair. Dr. X. O-Werder, of Pittsburg, Pa., read a paper on A CASE OF BICORNIC UTERUS, UNILATERAL HEMATOMETRA, HEMOSALPINX AND HEMATOCOLPOS.

Dr. Briggs, of Sacramento, exhibited some obstetrical forceps invented by himself. He also read a paper on the FUNCTION AND FORM OF OBSTETRICAL FORCEPS.

Dr. Meade, of San José, Cal., in discussing the forceps, said that she considered the forceps too complicated and anatomically defective, as the pelvic curve was wanting. Great force is not necessary in delivering a child with forceps. They should be used for traction only during a pain. It was better to make traction at intervals for half an hour if necessary, than to use great force, as the soft parts would dilate better and the laceration be much less. She considered that it was too great haste and lack of anatomical knowledge that destroyed so many children taken with instruments and caused so much laceration of the uterus and vagina.

Dr. Mayer, of San Francisco, thought the instrument too complicated from an aseptic point of view.

Dr. Brown, of Mendocino, objected to the forceps exhibited on account of not having proper curve.

Dr. Briggs, in closing the discussion,

said that the curve was greater than it seemed, being equal to three inches. The handles were parallel to the axis of the blade, hence the curve appeared lessened.

Dr. Oscar J. Mayer, of San Francisco, read a paper on MASSAGE IN GYNECOLOGY. He said the object of uterine massage is to bring about a healthier state of the circulation and to impart tone to the various structures of the genital tract. The indications for massage in gynecology are the same as those for massage in surgery. He said by massage treatment we wish to produce:

1. Acceleration of the absorption and retrogression of inflammatory and traumatic exudation and deposits.

2. Stretching, loosening, disintegrating cicatricial or hypertrophied connective tissues, caused by inflammatory processes.

3. Stimulation of the circulation and restoration of the normal elasticity and tone in (*a*) contracted, hardened and hypertrophied tissues, or, (*b*) relaxed tissues.

The sphere of usefulness of pelvic massage may be tabulated as follows:

1. In pelvic exudations and hemorrhagic infiltrations.

2. In chronic parametritis and perimetritis.

3. In retroversion of the uterus.

4. In chronic metritis.

5. In prolapsus of the uterus and vagina.

Massage is contraindicated in all acute diseases of the genital tract requiring perfect rest of the whole body or of the genital tract alone.

The best and quickest cures from massage are observed in chronic diseases following the puerperal state. A longer time is required in diseases following acute inflammatory processes, also where coincident with anomalies of position of the pelvic organs, especially in retro-deviations of the uterus. Even if we do not succeed in some cases in restoring the uterus to its exact normal position we can obtain a symptomatic cure without recourse to surgical procedure. The combination of massage with electricity is to be recommended in relaxations of the supports of the uterus provided the structures are intact.

In conclusion, the doctor said that massage does not set up for itself the claim that it constitutes an independent and sufficient form of treatment. It is only a mechanical therapeutic agent, intended to be used in combination with other tried and accepted remedies, in effecting a permanent cure or in considerably lessening the time formerly required therefor. American gynecologists have been somewhat slow in accepting massage as a new remedial agent and have been in doubt as to the beneficial results that have been claimed for it. But the constant encouraging reports of European authorities are bound to work a change in this American sentiment. The skepticism of to-day will soon be converted into the faith of to-morrow.

Dr. Barbat, of San Francisco, bore testimony to the great good he had seen accomplished by massage combined with electricity and glycerine tampons, even in cases where the removal of ovaries had been recommended by competent physicians. He looked upon massage as one of the greatest remedial agents of the day.

Dr. Shuey, of Oakland, said that she had used massage in the painful menstruation of young women with the result of perfect relief from pain. They were cases of long standing, where none but medicinal treatment had been tried. She used the massage every day for three or four weeks, and during the menstrual period for three or four months afterward.

TUBERCULOUS ENDOCARDITIS.—A patient suffering from tuberculosis, under the care of Mouisset, of Lyons, died of acute endocarditis. Portions of the endocardial lesion were inoculated into a guinea-pig by Courmont, who reports (*British Medical Journal*) that the animal became tuberculous; it presented enlargement of the glands in relation with the point of inoculation in the thigh, and commencing tubercle in the lungs. Courmont concludes that the endocarditis in the patient was tuberculous.

MEDICAL PROGRESS.

Caustics in Malignant Growths.—Of late the tendency seems to be to use caustics in treating certain malignant growths, especially those of the skin and superficial parts. Dr. John Parmenter, in the *Journal of the American Medical Association*, advocates the use of caustics on the ground that recurrence of the growth is less frequent, that caustics have a selective action and that they reduce enlarged lymphatics near the seat of disease. We must use the proper caustic and use it intelligently. Of the various escharotics the author prefers Bougard's or Vienna paste, the composition of which is as follows :

Wheat flour . .	60 grams.
Starch . . .	60 "
Arsenic . .	1 "
Cinnabar . .	5 "
Sal ammonia . .	5 "
Corrosive sublimate.	0.50 centigrams
Sol. chloride zinc at 52.	245 grams.

From his work Dr. Parmenter concludes as follows :

1. The value of caustics in the treatment of malignant disease depends upon the use of proper caustics and their intelligent application in suitable cases.

2. A proper caustic is one which completely destroys and removes the malignant tissue.

3. Mild caustics are inefficient and dangerous, and therefore to be avoided.

4. Bougard's paste is the most generally useful escharotic.

5. Proper technique in application accentuates the value of caustics.

6. The suitable cases are those which have a limited extent and are easily accessible, or in other words, cancer of the skin, lip and external ear, in their incipient stages.

7. The prognosis should be most excellent, cure resulting in the vast majority of cases when treatment is early and thorough.

* * *

Scopolamine in Ophthalmic Practice.—Dr. W. Harvey Smith, in the *New York Medical Journal*, in making a number of observations on the value of scopolamine in ophthalmic practice, concludes :

1. That the toxic effects of scopolamine used in one-tenth and one-fifth per cent. solutions are easily produced, but can readily be avoided if the lids be everted or the nasal ducts compressed at the time of instillation.

2. That in diseased conditions of the eye scopolamine is quite as useful a drug as atropine.

3. That in refraction work complete and thorough paralysis of accommodation with the maximum of mydriasis can be produced in from twenty minutes to half an hour, where the drug is used *coup sur coup*, and that the duration of its effect is from five to eight days.

4. That its greatest value lies in the rapidity of its action, which renders it specially useful for purposes of examination in refraction cases and in diseased conditions of the interior of the eye.

* * *

Preservation of Organized Sediments in the Urine.—Bohland (*British Medical Journal*), recommends the following method : The deposit is obtained by standing or by means of the centrifugal machine. The supernatant fluid is poured off, and the deposit washed with saline solution and transferred to Müller's fluid, which is renewed every three or four days. After a fortnight the Müller's fluid is drained off, and the after-hardening completed in absolute alcohol. Epithelium, leucocytes, and casts are readily recognized. If examined as soon as taken out of Müller's fluid the formed elements appear yellow, and hyaline casts are thus easily seen. Alcohol alone, chromic or picric acid, are unsuitable for hardening. The sediment can be stained. A drop of the deposit in alcohol is put on a cover-glass, and a thin film obtained. This is allowed to evaporate, and is then stained with Ehrlich's neutrophile mixture. The author's preparations lasted only a few weeks, but the value of the hardening method for class purposes is obvious. Mononucleated leucocytes were found in parenchymatous and interstitial nephritis as Senator pointed out, very few polynucleated cells

being seen. The author has stained deposits with Weigert's fibrin stain, but he could never demonstrate fibrin in the casts.

* * *

Trional in Delirium Tremens.—Dr. Russell Bellamy, in treating ten cases of delirium tremens with trional, a new hypnotic, records the results of his work in the *New York Medical Journal*, as follows :

1. Delirium was controlled with greater rapidity and safety by trional than by other hypnotics.

2. In the majority of cases a marked stimulant effect was observed, possibly on account of the methylic and ethylic elements which enter into the composition of the drug.

3. On account of the low temperature noted in all cases, trional must possess antipyretic properties, thereby simulating its allies of the phenol group.

4. It was always well borne by the stomach, and in one case was rapidly absorbed when administered *per rectum*.

5. No unpleasant after-effects were observed, and in all cases, except one, and a tuberculosis complication, recovery was speedy.

* * *

Excision of the Kidney and Ureter.—P. I. Postnikoff (*British Medical Journal*) records the case of a woman whose peritoneal cavity was opened on account of suspected hydronephrosis. The kidney was actually found distended, its glandular substance being almost entirely atrophied. The ureter was greatly dilated and its walls thickened, while the probing showed that its vesical end was blocked by calculi. The latter—fourteen in number—were extracted, after which the ureter was tied close to the bladder, and excised together with the kidney. For about forty-eight hours the patient suffered from obstinate vomiting, causing alarming prostration, but under the energetic use of stimulants, she gradually rallied, and ultimately made a complete recovery, the wound healing without any complications. During the few days immediately following the operation the daily quantity of urine varied from 200 to 400 c.c., but subsequently rose permanently to the standard. As regards the removal of a whole ureter, the case is believed by the author to be unique.

* * *

Tenotomy of the Eye Muscles for Epilepsy.—Dr. Casey A. Wood, in considering the treatment of epilepsy by tenotomy of the eye muscles and by other surgical means, concludes in the *New York Medical Journal* as follows :

1. Heterophoria in some form, latent or manifest, can be shown to exist as an ocular condition in fully ninety-five per cent. of all individuals.

2. Alone and when associated with ametropia it is not an uncommon cause of so-called asthenopia.

3. In the latter case the correction of the accompanying refractive error in the large majority of cases relieves all the symptoms set up, both by the ametropia and muscular anomaly ; when it does not, the heterophoria may be said to be responsible for the asthenopia.

* * *

Hemorrhage after Operations on the Nasal Septum.—Dr. A. C. Getchell, in the *Boston Medical and Surgical Journal*, reports several cases of serious hemorrhage after operations on the nasal septum, from which he concludes that:

1. Operations upon the nasal septum may be followed by hemorrhage sufficient to very materially affect the health of the patient.

2. The artery of the anterior (cartilaginous) septum may lie near the surface, be of considerable size, and if atheromatous may cause serious hemorrhage.

3. Operations upon the nasal septum in adults should be advised only after carefully considering the good to be accomplished and the possible risk incurred.

* * *

The Rational Treatment of Appendicitis. — Dr. W. G. Ashton, in the *International Journal of Surgery*, thinks the profession is divided into three classes as regards appendicitis. The first class look upon it as a purely medical disease ; the second class are uncertain and the third class believes

that surgery alone is the only rational treatment of this disease. He wishes to show that no one at the beginning knows what course the attack will take, but he believes that all forms are dangerous to life. His conclusions are :

1. That it is impossible with our present means and methods of diagnosis to know the nature of the pathological changes taking place during the course of an attack of appendicitis.

2. That all forms of appendicitis are dangerous to life, as it has been demonstrated that germs pass through the walls of the appendix without the presence of either ulceration or perforation.

3. That surgical interference is indicated in primary and secondary attacks of appendicitis, so soon as the diagnosis is clear.

4. That surgical interference is not advised during an acute attack of appendicitis, except when grave symptoms intervene, unless a competent surgeon is at hand. Under these circumstances the case should be operated upon after the so-called recovery.

* * *

The Pessary in Retroversions.—Dr. F. H. Davenport has contributed an article to the *American Journal of Obstetrics* on the ultimate results of treatment of backward displacements of the uterus by the pessary, with especial reference to the Alexander-Adams operation, and he sums up the matter as follows:

1. In cases of uncomplicated retroversion of retroflexion of the uterus the choice of treatment lies between shortening the round ligaments and the wearing of a pessary.

2. A cure, either anatomical and symptomatic, or symptomatic alone, may be confidently expected from the use of a pessary in about twenty-five per cent. of all cases.

3. Where a cure is effected it is usually within a year or a year and a half after the beginning of treatment.

4. A large proportion of those not cured can wear a pessary without discomfort and do not wish an operation.

5. The operation for shortening the round ligaments should be limited to those cases where a pessary cannot be worn, to those who prefer it to wearing a support for years, to cases where vaginal treatment is inappropriate, and as supplementary to other operations.

* * *

The Minute Anatomy of the Fallopian Tubes.—Dr. Mary A. Dixon Jones contributes to the *American Journal of Obstetrics* an article on the minute anatomy of the Fallopian tubes, based on a ten years' microscopical study of normal and pathological tubes. She has long been convinced that a careful study of this anatomical structure would reveal a more complicated composition. The results of her researches may be summed up as follows:

1. In the tube wall are six layers of smooth muscles. The two main layers are the circular and the longitudinal. These interlace; the circular has the broader area and is nearer the caliber, the longitudinal is nearer the peritoneum.

2. The inner surface of the tube wall is made up of myxomatous or myxofibrous connective tissue, which in turn is supplied with two muscle layers, a broader longitudinal and a narrow circular, both interlacing.

3. The mucosa has folds with many ramifications, serving for the occlusion of the calibre during life. These folds are the result of alternate contractions and extensions of the two muscle layers of the mucosa, the transverse and longitudinal, which are visible throughout all the folds and all the ramifications, arranged in bundles close beneath the epithelial layer.

4. Outside of the longitudinal layer of the tube wall is the layer of blood vessels, mainly arteries and veins, in an arrangement similar to that known to exist in the wall of the uterus.

5. Beyond the vascular layers are the two narrow layers of smooth muscle fibers, both being oblique, both traceable from the uterine ostium up to the fimbriated extremity of the tube, and they correspond to the two oblique layers of the wall of the uterus. The two oblique layers are bordered outwardly by the peritoneum, and seem to serve mainly for the regulation of the

afflux of blood in the subjacent arteries and veins.

6. The circular and longitudinal muscle layers are antagonistic in their action. If one layer is contracted the other is relaxed. Again, the two muscle layers of the tube wall proper are antagonistic in their action to the muscles of the mucosa. The contraction of the muscles of the tube wall is accompanied by a corresponding relaxation of the muscles of the mucosa. Within the folds the primary, secondary, and tertiary ramifications are produced by alternate contractions of smaller portions of the muscle layers of the mucosa.

* * *

Treatment of the Milk Teeth.—Mr. Edmund Owen read a short but interesting paper, which is reported in the *London Lancet*, on this subject at the last meeting of the Odontological Society. He asked the question whether it was always the best plan to stop decayed milk teeth, and whether it was really an advance in treatment. He thought that in some other branches of surgery many so-called improvements had in fact put back the dial of surgery and that dentists were carrying conservative treatment too far, hesitating to extract from fear that the due development of the jaws would be interfered with, or that the second teeth would have to scramble for position after premature loss of the temporary teeth; but in his opinion the development was due to the presence of the tooth sacs contained in the substance of the bone, and, with regard to the crowding, should it take place, it could be easily remedied by careful watching and weeding out if necessary. He said: "There is one point in connection with the dental surgery of children's teeth which I am sure has not received the attention which it so urgently demands—it is that children's mouths should undergo regular periodical inspection." Mr. Owen laid especial stress upon the removal of carious teeth where there was an enlargement of a lymphatic gland in the neck, which, he said, so many dentists refused to do, probably foreseeing some possible contingency in connection with the eruption of the permanent teeth. Where the pulp of a tooth was exposed it was an extremely painful and difficult thing to do to clear out each fang thoroughly, and unless this were done it was merely "rolling a stone over a whited sepulchre," and further trouble was inevitable. The very germ with which the dental surgeon temporized in the alveolar region was often subsequently encountered in a submaxillary glandular abscess.

* * *

Primary Carcinoma of the Gall-Bladder.—Dr. Delano Ames has reported, in the *Johns Hopkins Hospital Bulletin*, three cases of primary carcinoma of the gall-bladder, the chief points of interest in one case being the rapidity with which the unfavorable symptoms developed; the rapid apparent increase in the size of the right lobe of the liver while the left remained normal; the intermittent swellings in the right hypochondrium; the absence of jaundice, cachexia and emaciation; the presence at autopsy of apparent disintegrating gall-stones. After going over the history of the disease, its symptoms, pathology and the relation of chololithiasis to it, he concludes that:

1. Primary carcinoma of the gall-bladder is much less uncommon than was formerly believed. 2. It occurs most frequently in women, the ratio being 3–5: 1. 3. It is a disease more particularly of the middle decade of life. 4. Gall-stones are found in from 91–95 per cent. of the cases, and probably bear a causative relation to the disease. 5. Metastasis is not extensive; invasion of neighboring organs by continuity, common. 6. Adhesions to adjacent organs frequently occur. Ulceration and perforation are more rare. 7. Pain, jaundice, cachexia, emaciation, tumor, indigestion, nausea, vomiting, constipation or diarrhea, with occasional ascites and edema, are the chief symptoms. 8. Pain occurs in 62 per cent. 9. Jaundice occurs in 69 per cent. 10. Tumor occurs in 68 per cent. 11. The disease is always fatal, and usually in a short time, the average duration varying according to the best authorities from 3 to 6⅔ months. 12. Death is due to exhaustion, peritonitis, metastasis to other organs, and to biliary obstruction.

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See also Publishers' Department, Page 296

BALTIMORE, JULY 28, 1894.

Unclean Cities.

THE truth must often give way to municipal pride and when Mr. Albert Shaw, of the *Review of Reviews*, undertakes to prove the sanitary regeneration of Hamburg, he omits important parts of his description. As Hamburg is an important port both for North and South America, it is reasonable to suppose that the whole Western Hemisphere would be deeply interested in her cleanliness. Mr. Shaw, in commenting on Hamburg, in the June number of the *Atlantic Monthly*, says that the magnificent system of filtration of the Elbe water which was in process of construction when the cholera broke out there the last time and which was hurriedly completed, had some defects which at the present time have been fully remedied, so that the drinking water of that city is safe and palatable.

Quite another picture drawn by a London *Lancet* correspondent would show that the half has not been told and that although the water may be good, the city itself in places is in a most unclean condition and that both Koch and Pettenkofer are disgusted at its present condition. Compared with that modern city Berlin, Hamburg is a mine of archæological treasure, but with this naturally come filth and disease.

The town lies on a level with the sea and in part below the Elbe at high tide, and in some places there are canals filled with black-looking water where the falling tide lays bare under the windows of dwelling houses a slimy mud, over which the rats hold nightly revels. The death-rate of Hamburg corresponds with the income of the inhabitants. Where good, sound, healthy houses were inhabited by dirty people, there were few cases of cholera, but where clean people lived in filthy houses there cholera was prevalent.

The authorities of Hamburg, as Mr. Shaw has shown, have concentrated all their energies on the water supply, but they have done almost nothing to clean out the slums of the city. Some photographs which were taken of dirty parts of the town during the cholera epidemic and for which the photographer was heavily fined, show the exact condition of parts of the city. As the truth usually offends in such cases, it is easy to see that the fining of the photographer is an admission of guilt on the part of the town. The *Lancet* correspondent took several photographs and the result of his work showed as bad a state of affairs as the native photographer discovered.

The need of some stringent dwelling house law and a thorough cleaning out of the slums of Hamburg will be the only effective means of making the place cholera proof, in addition, of course, to the good drinking water which has been introduced at such great expense.

In view of the close connection of Hamburg with so many other countries, the *Lancet* has done a good work in bringing the bad state of affairs to public notice and it may have the desired effect of preventing future outbreaks of cholera in that city and making her a menace to other countries.

* * *

Sanitary Treatment of Pulmonary Consumption.

THE present method of treating pulmonary consumption in private practice has not yielded the results desired and after taking first one drug or method and then another, the tendency now seems towards natural methods, such as climate, air

and good food. It has long ago been pointed out that a carefully prepared dietary list faithfully followed will do much towards curing early cases of phthisis, but a few advanced physicians are trying, with no small degree of success, the sanitarium treatment of consumption, with the result of seeing cases arrested in their progress and practically cured.

Dr. Vincent Y. Bowditch, of Boston, in a communication before the American Climatological Association and published in the *Boston Medical Journal* shows what can be done in a sanitarium, even in such an undesirable region as outside of Boston. Several years ago, he established through the munificence of friends a small sanitarium for treating consumption at Sharon and although his space is very limited and he has only nine beds, he has treated about half a hundred of patients with extremely satisfactory results.

He was at first opposed to the bringing together of tuberculous cases under the prevalent idea that such cases would form a focus of infection and spread the disease. But he found that by taking incipient cases only and by using the most careful preventive methods of disposing of the sputum, in which he had the hearty co-operation of his assistants and of the patients themselves, and by using careful means of removing dirt and dust from the room, by demanding that a certain part of each day be spent out doors and by using occasional drugs when necessary and in picked cases using the pneumatic cabine, and also by taking care to remove cases not strictly incipient, he has succeeded in arresting, or actually curing, as many would say, about one-fourth or one-fifth of all those treated.

This only goes to show that while cod liver oil, tuberculin and all other vaunted specifics may fail and home treatment is not very successful, that sanitarium treatment yields excellent results even in such an unsuited region as near Boston. If every State would have a small hospital or one built on the pavilion plan, where suitable cases picked at the discretion of the physician in charge might receive such treatment as Dr. Bowditch has given his cases, many cures would follow where a bad family history would give a bad prognosis.

Care of the Teeth.

At the last meeting of the American Medical Association dentistry was recognized as a specialty of medicine and partly because the close connection between the condition of the body and that of the teeth has been brought into so much more prominence of late. Dr. Hugh Ripple, of Omaha, has noticed the effect of exercise on the teeth and in the *New York Medical Journal* shows very clearly how necessary it is to use the teeth more than we do. He may not believe that coming generations will be bald and toothless, but he does think that the more good, strong teeth are used the better it is for them.

A century ago New York, with a population of fifty thousand, had one dentist and much less attention was paid to the teeth then than now and yet there is abundant evidence to show that our forefathers had better teeth than we have. So important is the care of the teeth and such an effect have bad teeth on the general health that it is asserted that bad teeth will materially shorten life. While other organs are delicate in early life and increase in vigor as puberty is reached, the teeth, if not impaired by disease, remain about the same. They do not possess that recuperative power which so many organs of the body have. It is only faulty teeth that are attacked by decay and good teeth protected by enamel will always remain good.

It is the want of use of these organs that is making them worse. Children are given soft food when they should have something on which the teeth could be used, so that they may have exercise and life.

The permanent teeth do not appear until the fifth or sixth year, but they are all formed in the jaw and calcification is going on all the time, so that they are affected by exercise.

Dr. Ripple concludes that the remedy is in the hands of parents. If they will see that their children, at the earliest possible age, use their first teeth vigorously, they need have little anxiety in regard to the second set. In other words, if a demand is created for sound, solid teeth, nature will be almost certain to supply them. It is by no means difficult to teach children to chew their food. Nothing pleases small children more than to be allowed to nibble a hard biscuit or bite the meat from a bone. Nature prompts them to exercise their teeth in that way.

MEDICAL ITEMS.

The dengue fever has broken out at Key West, Florida.

Typhus fever has broken out in the dirtiest parts of Paris.

Helmholtz, the physicist and physiologist of Berlin, has been paralyzed.

Dr. Emory Lanphear has assumed editorial charge of the *St. Louis Clinique.*

Dr. John S. Billings and Dr. Henry M. Hurd have gone to Europe together.

The proposed memorial to Charcot will probably take on an international character.

Dr. A. L. Gihon, of the U. S. Marine Hospital, will spend a part of the summer in Europe.

Cholera continues to thrive in Russia and a few cases are reported in Germany and France.

A memorial of the late Billroth will be erected in the Rudolphinum Hospital in Vienna.

The American Physicians' Sanitarium Association has surrendered its charter and is a thing of the past.

Dr. Joseph Hartl, the celebrated Austrian anatomist, died recently in Vienna in his eighty-third year.

An International Congress for the protection of infant life was held in Bordeaux, France, this week.

Dr. Frank Smith is acting superintendent of the Johns Hopkins Hospital during Dr. Hurd's absence in Europe.

The Doctor and Druggist is the name of a new journal which has just made its appearance in St. Louis, Mo.

Dr. Joseph M. Mathews was elected President of the State Board of Health of Kentucky at its last regular session.

The American Electro-Therapeutic Society will hold its fourth annual meeting in New York at the end of September.

Dr. V. P. Gibney has been elected Professor of Clinical Surgery in the New York College of Physicians and Surgeons.

The plague seems to be decreasing in Canton, while it is increasing in Hong Kong. The reports that there is cholera in China are false.

Cholera is spreading in some parts of Europe and Asia, but there seems to be no danger of its reaching America this year.

Dr. Barton Pitts, formerly of Baltimore, has been elected to the chair of ophthalmology in the Ensworth Medical College of St. Joseph, Mo.

The American Academy of Medicine announces that its nineteenth annual meeting will be held at Jefferson, N. H., August 29 and 30, 1894.

Dr. James R. Church and Robert M. Smith are respectively resident and assistant resident physicians in the Emergency Hospital in Washington, D. C.

Dr. A. F. A. King has resigned his position as dean of the Medical Department of the Columbian University at Washington and has been made Dean Emeritus.

Dr. R. Harvey Reed succeeds Dr. J. F. Baldwin as editor of the *Columbus Medical Journal.* Dr. Baldwin has occupied the editorial chair for eighteen years.

The Railway Surgeon is a new medical monthly published in the interests of the railway surgeons. It appears from Chicago and Dr. E. H. Reed is the editor.

The American Medico-Psychological Association has bought the *American Journal of Insanity* and Dr. Richard Dewey, assistant to Drs. Edward Cowles and Henry M. Hurd, of Baltimore, will edit it.

The late Dr. S. J. Moore, of Glasgow, has bequeathed the residue of his estate, after the payment of other legacies, etc., to found a convalescent home for nurses, to be called by his name. The amount of the bequest is likely to be over $200,000.

Dr. William T. Howard, Jr., has resigned his positian as Lecturer on Pathology at the Baltimore Medical College to accept the position of Assistant in Pathology in the Western Reserve University at Cleveland, Ohio. Dr. Van Ness will probably succeed him here.

The Supreme Court, at Hartford, Conn., has decided, in a suit brought against the New Briton School Board to compel them to admit unvaccinated children to the public schools, that the law giving the School Board authority to order all school children vaccinated, and to exclude those not vaccinated from the schools, is constitutional.

BOOK REVIEWS.

WHERE TO SEND PATIENTS ABROAD FOR WATER CURES AND CLIMATIC TREATMENT. By Dr. Thomas Linn, Doctor of Medicine, Faculty of Paris, etc. Detroit: George S. Davis, 1894. Pp. 76. Price, paper, 25cts.; Cloth, 50 cts. Physicians' Leisure Library.

The author has given a list of the places abroad where patients should be sent, because in his opinion they will go abroad and it is the physician's duty to be acquainted with the water cures and health resorts in Europe. He is correct in intimating that most physicians have a very hazy idea of the health resorts of the European continent. He says that it is more the water itself with the fresh air, change of scene and habits, rather than any medicinal property in the water, that works the cure. He divides the mineral waters into the sulphurous, saline, purgative, alkaline and ferruginous. He gives advice not to swallow a large amount of the water as soon as the springs are reached, but to consult the resident physician and begin right. He shows the best seasons for visiting these places and the manner and method of treatment. One good piece of advice he gives which invalids who go to Europe for their health would do well to follow, and that is not travel south too quickly and to remember that the food and clothing must be modified to suit the place. At the end of the work is an alphabetical index of maladies, with names of resorts in Europe where patients may be sent. While this little work makes no pretensions to be scientific, still it will be found very useful and may serve as a guide to one in the dark as to European health resorts.

SYPHILIS IN THE INNOCENT (Syphilis Insontium), Clinically and Historically considered with a plan for the Legal Control of the Disease. By L. Duncan Bulkley, A. M., M. D., Physician to the New York Skin and Cancer Hospital, etc. New York: Bailey & Fairchild. Pp. 416, cloth, 8vo. Price, $3.50.

It has been too much the custom to regard syphilis as entirely a venereal disease and to assume that it is always contracted through some connection with prostitution.

The author of this book has done good service in trying to show the innocent occurrence of the malady and the modes of infection whereby it is innocently acquired by means wholly unconnected with the venereal act.

He has devoted ten years to the study of the subject and has consulted the writings in no less than a dozen languages in collecting his material. His own records show as many as 116 cases of extra-genital chancres, while in another table he has collected no less than 9,000. The volume is the most complete monograph on this subject which has yet appeared. It is a most valuable book to those who are interested in the history and study of this disease, a malady of such wide distribution as to make it one of the gravest which inflict mankind.

TEXT-BOOK OF MEDICAL AND PHARMACEUTICAL CHEMISTRY. By Elias H. Bartley, B. S., M. D., Professor of Chemistry and Toxicology in Long Island College Hospital, etc. Third edition, revised and enlarged, with 84 illustrations. Philadelphia: P. Blakiston, Son & Co. 1894. Pp. 683. Price, $3.00.

This work has been enlarged and rewritten and changed to suit the lengthened terms in the colleges. The new synthetical compounds are noticed and new chapters on physiological and clinical chemistry, the chemistry of nutrition, foods, digestion and urine are added. There is no change in the spelling.

KEEP YOUR MOUTH SHUT. A Popular Treatise on Mouth-breathing; Its Causes, Effects and Treatment. By Fred. A. A. Smith, M. D. C. M. Glas. To which is added An Appendix on Ophthalmia in New-Born Children. By Dr. Smith and Dr. Swan M. Burnett. Boston: Roberts Brothers. 1893. Pp. 73. Price, 50 cents.

This little book with the very startling title was suggested to the author by the many cases of nasal obstruction in children which were brought to him. He gives a very common-sense description of the proper manner of breathing and states the diseases which may be brought on by abnormal breathing. The book is so written that lay and medical alike will understand it.

REPRINTS, ETC., RECEIVED.

A Sexualization for the Prevention of Crime and the Arrest of the Propagation of Criminals. By F. L. Sim, M. D. Memphis, Tenn. Reprint from the *Memphis Medical Monthly*.

A Preliminary Report on the Morphology of Ovarian and Myomatous Tumors. By Howard A. Kelly, M. D. Reprint from the *New York Journal of Gynecology and Obstetrics*. 1893.

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NOTES.

CHLORATE of soda in doses of two to four drachms daily is beneficial in cancer of the stomach.

*

PIMPLES and comedones are said to yield to a lotion of alcohol, three ounces, and salicylic acid, one drachm.

*

HYDRONAPHTHOL has been very successfully used recently in the treatment of pulmonary consumption.

*

AN ointment of myrrholine, one part, and vaseline, two parts, is said to be curative in eczema about the nostrils.

*

CAFFEINE in various combinations is said to be a most powerful stimulant in those diseases of children accompanied by a feeble circulation.

*

SOZOIODOL is very efficacious in eczema of the ear and nose. A one to two per cent. ointment of sozoiodol with lanoline is a good combination.

*

MYRRHOLINE, which is a solution of myrrh in its own weight of oil, is said to be very useful in laryngeal tuberculosis. It is given in capsules of three grains each, with five grains of creosote.

READING NOTICES.

Listerine.—Thirty-two pages devoted to the management of Summer Complaints of Infants and Children may be had upon application to the manufacturers of Listerine—Lambert Pharmacal Company, St. Louis.

*

Bromidia.—Dr. Angelo de Bellomi, of Citta di Amandola, Italy, July 22, 1893, says: I am pleased to inform you of the successful results by the use of Bromidia as hypnotic and sedative. I prescribed it for a lady suffering from severe vomiting due to pregnancy, and which threatened to cause abortion from denutrition. I had previously tried opium, chloroform, creosote, and oxalate of cerium, all without effect. I gave ten drops in a little sweet wine three times a day before meals. The vomiting ceased the first day, four days later I was able to discontinue the use of Bromidia, and now after a month there has been no return of the vomiting, and the patient is perfectly well.

*

Celerina.—J. D. Spitzmesser, M. D., Windfall, Ind., says: I was called to see Mrs. W., who had been treated by eight physicians for muscular rheumatism of a shifting character, invading nearly all parts of her body and limbs, and a leucorrheal discharge since birth of last child. Patient confined to her bed most of the time, coughing and expectorating to an alarming extent, and without hope of ever getting well. I prescribed:

℞ Celerina . . . . 7½ ounces.
Tinct. Rhus. Tox . . . 10 drops.
Fl. Ext. Cimicifuga . ½ ounce.
M. Sig.: Tablespoonful every three hours.
℞ Aletris Cordial - . 8 ounces.
M. Sig.: Teaspoonful alternately with above.
Locally applied:
℞ S. H. Kennedy's Ext. Pinus Canadensis (Dark) . . . . 1 ounce.
Boracic Acid . . . 30 grains.
Glycerine . . . 1 ounce.
M. Sig.: Lamb's wool thoroughly saturated, and womb kept in place by impaction of the above.

Patient was received May 16, and discharged October 26 of the same year, cured. This case took three bottles of Aletris Cordial. I have other cases that I have treated in a good deal the same manner, with equally as good results, and my shelves are never complete without the above remedies in stock.

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ORIGINAL ARTICLES.

AMBROSE PARÉ, THE FATHER OF FRENCH SURGERY. 1509–1590.

Read Before the Des Moines Medical Society, at Ottumwa, Iowa, June 21, 1894.

By James Moores Ball, M. D.,

Professor of Ophthalmology and Otology in the St. Louis College of Physicians and Surgeons, St. Louis, Mo.

Great good sense, wonderful industry, remarkable opportunities, and an untiring and unconquerable ambition, have combined to render the name of Ambrose Paré celebrated in the annals of surgery. Born of humble parents, amid unfavorable surroundings, under circumstances which would have crushed a spirit less ambitious, Ambrose Paré, by his unaided efforts, made himself master of the surgical science of his day, commanded the confidence of emperors and peasants, of statesmen and soldiers, and left posterity the record of a life well spent. He marks the dividing line between the servile surgery of the ancients and the original, independent and progressive art of the moderns. Just as Vesalius, Eustachius and Fallopius dared to contradict the errors of thirteen hundred years, and correct the anatomical mistakes of Galen, so Paré brought about a new order of things in surgery. Firm in his convictions, honest in his statements, and accurate in his observations, this great man was far in advance of his age. The story of his life reads like a romance.

Paré was born at Laval, a small town in the province of Mayenne, in France, in the year 1509. His life was spent during a period of great and stirring scenes—a time remarkable in the history of the world. At the time of his birth the art of printing had been invented less than sixty years; the existence of a new continent had been proclaimed by Columbus seventeen years; Martin Luther was delivering Biblical lectures in the University of Wittenberg, and preparing to shake the foundations of the theological world; Aristotle, of Italy, was writing immortal verse; Erasmus, residing in the same sunny clime, was delighting the world with his matchless scholarship and educating the young son of James IV of Scotland; and Copernicus, while studying the revolutions of the heavenly bodies, had not dared to proclaim his views. Louis XII, of France, was engaged in war with Italy. Henry VIII had just succeeded to the English throne. Maximilian I ruled the land from the Danube to the Zuyder Zee.

The same year that Paré first saw the light of day, there was ushered into the world one Michael Servetus, destined to discover the lesser circulation and die by slow torturing fires; and John Cal-

vin, the theological bigot of Geneva. Paracelsus, that compound of science, eccentricity and charlatanism, was in his sixteenth year. Realdus Columbus, celebrated as an anatomist, was fifteen years of age.

The early education of Paré was obtained from a priest. While yet in his teens he was apprenticed to a barber-surgeon, who instructed him in minor surgery. While thus engaged, Laurent Colot, the celebrated lithotomist, chanced to visit the town for the purpose of operating for stone. Paré was present, and was so struck with admiration at the result of the operation that he resolved to devote himself to the higher branches of surgery, an art which was then almost exclusively in the hands of the barbers. With this object he set off for Paris, where Jacques Goupil, one of the professors in the College of France, acted as his preceptor. Here the masters explained to him the works of Lanfranc, Albucasis, Guido de Chauliac, and John de Vigo, the only surgical text-books of the times. Soon Paré became interne to that famous hospital, the Hôtel Dieu, where he remained for three years. During this time Paré was engaged in teaching anatomy. In 1536, in his twenty-seventh year, he received the appointment of military surgeon and was directed to accompany René de Montjean to Italy. After the surrender of Turin, and the death of Montjean, Paré returned to Paris and began the practice of surgery.

The three years spent in campaigning were of great value to Paré and during this time he made some important observations. In the treatment of gun-shot wounds, the teachings of John de Vigo, physician to Pope Julius II, had been followed implicitly. Such injuries were regarded as poisoned wounds and the practice was to cauterize them with boiling oil, or the hot iron, while alexipharmics were administered internally. John de Vigo assures us that the danger of these wounds results from the round form of the balls, their degree of heat, and the poisonous qualities that the powder communicates to them. This theory, so destructive in its effect, received universal credence until Paré arose to combat it. After the battle of Pas-de-Suze, the supply of boiling oil having given out, it was observed on the following morning by Paré that those wounds looked best which had not been dressed with hot oil; and he also noticed that such patients showed less febrile reaction than the others. It required great courage for him, a young man without name or authority, to combat a doctrine so universally accepted; but Ambrose Paré was not the man to be overawed by weight of authority when his own sober judgment taught him differently.

In Paris, Paré was interviewed by Sylvius de la Böe. Malgaigne says: "This interview was honorable in all respects to both." Sylvius, whose teachings attracted more auditors than those of Fernel, even invited the young surgeon to dinner, and heard with great attention the observations and experiments on which Paré had established his doctrines on gun-shot wounds, and was so much struck with them that he besought, him with great warmth, to write them out and make them public. Paré felt sensibly this encouragement, coming from so high a source, and prepared his text, drew the figures, and in the year 1545, at Virant Gaulterot's, sworn bookseller in the University of Paris, that little work which marked in a manner so glorious the revival of French surgery, was published, with the following title: "The Manner of Treating Wounds made by Arquebusses and other Fire Arms, and those made by Arrows, Darts, and the like; and also of Burns, made especially by Gunpowder; Composed by Ambrose Paré, Master Barber-Surgeon, Paris."

In a few months a second edition was issued. In both editions the use of the actual cautery was advised to check hemorrhage. Paré, however, was thinking, day by day, of a plan by which hemorrhage could be controlled without the frightful torture of the hot iron. He resolved to test his theory and finally, at the seige of Dampvillier, in the year 1552, an amputation was made upon the person of M. de Rohan, and,

for the first time in the history of surgical science, Ambrose Paré ligated the bleeding vessels. Fortunately the patient recovered and, full of joy at having escaped the red-hot iron, said that he had parted with his leg on very good terms.

The young surgeon had made two great discoveries: By the first he saved from cauterization all who had simple gun-shot wounds; by the second all who suffered an amputation were spared the tortures of the actual cautery. And, in the language of Malgaigne, "Military surgery, which till that time had been a torture, became a blessed art, and it was a barber-surgeon who produced the double marvel."

The practice of ligating an artery was entirely new, but the idea was old. Galen, Celsus, Avicenna and Albucasis had all spoken of the tying of arteries and veins, but there is no evidence to show that they practiced it. For centuries the actual cautery had been the principal means of checking traumatic hemorrhage. Sometimes, by way of variety, hot oil or boiling pitch were applied to the bleeding surface. The discovery of Paré revolutionized the practice of surgery and brought on his devoted head a torrent of abuse. Like Harvey at a later date, Paré suffered in his practice for a time. Of all his enemies, Gourmelen, President of the College of France, was the most clamorous. At the present day he is remembered only for his opposition to the great surgeon. "It was then," said Gourmelen, "very forward, rash and presumptuous in a certain individual, to venture upon condemning the cauterization of bleeding vessels after cutting off a mortified limb, a method so highly and continually commended and approved by all the ancients, teaching in opposition to that, without authority, without good sense, some new method of his own, of tying arteries and veins." He called Paré a bloodthirsty cruel rascal, while Paré, stung to the quick, sometimes lost his temper but generally conducted his defence with admirable coolness, as the following will show:

"You boast, M. Gourmelen, that you will teach me my lessons in surgery, and my operations; but in that, I believe, you are a little mistaken, for my education has been quite after another fashion. I have learned my art, not in my closet; no, nor by hearing the discourses of physicians, though that also I have not despised; but in the Hôtel Dieu, where I lived for three years, seeing many diseases, and practicing many operations upon the living body, and learning also much anatomy from the dissection of the dead. But," he continued, "I have yet more to boast of, for, being in the service of the King of France, I have, in my time, served four successive Kings, having followed them in battles, skirmishes, and assaults; sometimes I have been in sieges, and sometimes shut up with the besieged, curing their wounds." . . . "And last of all, I have lived in this great renowned city of Paris many long years, where, thank God, I have been held in some repute, and ranked at least equal to my peers, insomuch that there have been few difficult or celebrated cures in which my head and hand have not been employed. How, seeing these things, dare such a man as you, who has made surgery no part of your study, talk of teaching me?"

Paré, although proud of his discovery, arrogated nothing to himself, but with true piety ascribed it all to God. He says: "I think it was taught me by the special favor of the sacred Deitie; for I learnt it not of my masters, nor of any other, neither have I at any time found it used by any. Only I have read it in Galen, that there was no speedier remedy for staunching of blood than to bind the vessels through which it flowed towards their roots, to-wit, the liver and the heart."—(Johnson's translation, London, 1634.)

Nor was the use of the ligature the only discovery made by Paré. He was the first to employ the twisted suture in the operation for hare-lip; to extract cartilaginous bodies from the knee-joint; and to perform podalic version in difficult labor. He was a man of great mechanical genius, as is evidenced by the large number of new instruments and appliances found in his book. He gave

the first account of what is now incorrectly described as Hey's saw, and the club-foot boot, claimed to have been devised by Mr. Syme, of Edinburgh. Among the many wood cuts of curios, one sees artificial eyes, ears, noses, teeth, arms, legs and hands.

Surgeon successively to Henry II, Francis II, Charles IX, and Henry III, it was said of Paré that "the Kings of France transmitted him to their successors as a legacy of the crown." These monarchs were all warmly attached to Paré; he was at once their privy-councilor and trusted surgeon, and his influence over them was by no means small. Let it be said in his honor that this influence was never exerted in an unjust cause. So great was the power of this good man over Charles IX, that he was enabled to put a stop to the massacre of St. Bartholomew (August 24, 1572), when 70,000 Huguenots were murdered in Paris and various parts of France. The details of that horrible event are well known. For years, Huguenots and Catholics had been at enmity; and affairs had at last reached such a crisis that the bloodthirsty mother of Charles deemed it necessary to kill all the Huguenots. For three days and nights these unfortunates were hunted like the beasts of the field. Helpless infants, old men and women were slain by hired assassins. The streets of Paris were blocked by the bodies of the dead. How long the slaughter would have continued is impossible to say, had not one man, and he a Huguenot, done his duty. That man was Ambrose Paré. "It was not long," says the Duke of Sully, who has so graphically described the scene, "before Charles felt the most violent remorse for the barbarous action to which they had forced him to give the sanction of his name and authority. From the evening of the 24th of August, he was observed to groan involuntarily at the recitation of a thousand acts of cruelty, which every one boasted of in his presence. Of all those who were about the person of this prince, none possessed so great a share of his confidence as Ambrose Paré, his surgeon. This man, although a Huguenot, lived with him in so great a degree of familiarity that, on the day of the massacre, Charles telling him the time was now come for him to turn a Catholic, he replied, without being alarmed: 'By the light of God, sire, you can not have forgotten your promise, never to command me to do four things, namely, to enter into my mother's womb, to be present in the day of battle, to quit your service, or to go to mass." The king soon after took him aside, and disclosed to him freely the trouble of his soul. 'Ambrose,' said he, 'I know not what has happened these two or three days past, but I feel my mind and body as much at enmity with each other as if I were seized with a fever; sleeping or waking, the murdered Huguenots seem ever present to my eyes, with ghastly faces, and sweltering in blood. I wish the innocent and helpless at least had been spared.'" The order which was published the following day, forbidding the continuance of the massacre, was the consequence of this conversation. At the time, Paré was 62 years of age, and of all his good deeds this was the greatest.

Nor was the influence of Paré over the populace less potent. Among the soldiers his presence was sufficient to inspire new courage. At the siege of Metz, when Charles V had surrounded the town with an immense army, and the garrison, comprising the flower of French nobility, were reduced by hunger and sickness to the utmost extremity, Paré was introduced into the city by stealth, much to the joy of the besieged, who exclaimed: "We have no longer any fear of dying, even if we should be wounded; Paré, our friend, is among us." At this period Paré had already passed sixteen years as an army surgeon and was known to all the officers and many of the rank and file. In his "Chirurgia," our subject tells how the Duke de Guise commanded that he "should be weel used, and bid mee I should not faile to be the next day upon the Breache, where I should meete with all the Princes and divers Captaines, which I did; who receaved mee with great joy, and did me the honor to imbrace me, and tell me I

was very welcome, adding withall that they did not feare to dye if they should chance to bee hurt." (Johnson's translation.) The next day after his arrival, Paré successfully trephined M. de Bugeud, who had been struck on the head by a piece of stone, and had remained insensible for fourteen days.

Paré became a member of the College of Surgeons in 1554, submitted to the examinations and received successively the degrees of Bachelor, Licentiate, and Master in Surgery. Although ignorant of Latin, Paré was received regardless of a statute which required that the candidate should know that language. He never wore the professor's cap and gown. He was tall in stature, with slender figure and a grave and dignified countenance. All his portraits represent him in his court dress, with the frilled collar characteristic of the age. No one can examine that grand old folio, "Opera Chirurgia," of Paré, without being overwhelmed with the thought that this work was penned by the intellect of a giant. Here we have nearly one thousand closely printed pages, over 300 illustrations—many of which contain numerous figures—which cost the author an almost fabulous sum. We find complete treatises on many subjects; on human anatomy; beasts, birds and fishes; monsters and prodigies; fractures and dislocations; tumors and wounds; artificial arms, legs and hands; amputations and ulcers; cauteries and ligatures; trephines and dental forceps, etc., etc.

So long as surgeons practice their beneficent art, the name of Ambrose Paré will be mentioned with reverence.

A CASE OF HYDROPHOBIA.

By William E. Magruder, M. D.,
Olney, Md.

(Reported by William E. Magruder, Jr.)

On February 3, Resin Perry, colored, of Colesville, Montgomery County, Md., aged sixty-seven, was attacked in the public road by a small dog which appeared to be rabid.

While actively fighting and running backward, Perry fell on a pile of stones and continued resistance on his back with the dog over him. He found a slight wound over his left eye and at the time thought he had received it in his fall on the stones, but soon his eye inflamed and remained very sore for several days, when it gave no further trouble.

After talking with friends he became somewhat scared and feared that he had been inoculated with rabies.

On April 11, the eye again became much inflamed and pains radiated from it over side of head and neck, followed by pains in the abdomen and limbs. He complained of having been unable to sleep and of inability to drink water the night before, although suffering from excessive thirst.

On the 13th, spasmodic contraction of the diaphragm occurred and the idea of swallowing became abhorrent. Seen on the 14th, when inability to swallow was complained of and even the suggestion of drinking gave what he expressed as "pain in the stomach and takes away my breath," and said that if he could only take some medicine which would enable him to drink he would get well.

When induced to attempt to drink, he would scream and run across the room imploring that the water be taken away from him and out of the room, returning soon to the couch exhausted and out of breath. The same phenomenon was produced when the door blew open and when the physician washed his hands in the room.

Patient frequently expressed surprise at his condition and wondered at the cause, laughing at jokes and joking between the paroxysms. Pupils contracted, hypodermic injections of morphia and atropia were administered and

tablets of the same were left with directions for their use at short intervals.

On the morning of April 15, patient seemed more quiet than before, slept little during the night, having numerous paroxysms followed by rational intervals. Respiration labored and pulse 110.

Administered 30 grains of chloral by rectum and 15 drops of fluid extract of gelsemium with morphia $\frac{1}{4}$ grain and atropine $\frac{1}{150}$ grain subcutaneously. Ordered 20 grains of chloral per rectum every two hours until quiet, but after the fourth dose the nurse could not administer it as characteristic paroxysms were produced.

Chloroform was used but had to be discarded for the same reason. One grain of morphia and $\frac{1}{36}$ grain of atropia with fifteen drops of fluid extract of gelsemium were administered hypodermically, and the dose was repeated every two hours until patient became thoroughly narcotized, since all attendants were afraid of him and he had become unmanageable. Until near the last of the attack there was almost constant spitting of viscid sputa.

Seen at 4 o'clock in a profound stupor with pupils slightly dilated, pulse 120, respiration deep and slow, face occasionally twitching and extremities cold, with muscles completely relaxed.

Thermometer used only once but no rise of temperature was observed at any time. Took no nourishment, but drank a little water on the 15th and 16th, amid spasms and screams.

Remained narcotized until 4 A. M. on the 17th, after several doses of the anodyne had been neglected, when he left his bed and walked across the room. Injections of anodyne resumed and repeated in twenty minutes by the nurse, who had become frightened, and continued every two hours until 10 o'clock, when they were discontinued. Stupor returned after 4 o'clock and he gave no further trouble.

At 11 o'clock pulse was 124 and compressible, respiration 16 and shallow. At 4 o'clock P. M. pulse was stronger and stupor less profound but mouth dry. Anodyne again administered and repeated when indicated until his death at 12 o'clock P. M. on the 17th.

There was no general spasm. A section of his medulla oblongata was sent to Dr. N. G. Keirle, of Baltimore, who makes the following report: "Trephined and injected subcutaneously two rabbits on April 19, with medulla oblongata of Resin Perry, rubbed up in bouillon; both developed rabies on May 3, and both died May 6."

Two Primary Carcinomata in the Alimentary Canal.—Lannois and Courmon (*British Medical Journal*) report the following case in a man, aged 77. His illness began five months previously with diarrhea, which lasted a month, and with difficulty in swallowing. On admission he could only swallow liquids. The obstruction was at 36 cm. from the teeth. There was now obstinate constipation. Nothing abnormal was found in the abdomen, except perhaps a diffuse resistance later to the right of the xyphoid cartilage. There was no jaundice. At the necropsy a tumor was found in the lower part of the œsophagus, producing almost complete obstruction; the microscope showed it to be a squamous epithelioma. In the duodenum and about the papilla a soft tumor was present. The pancreas and liver with their ducts were absolutely healthy. This tumor was a columnar carcinoma, and apparently presented a similar degree of invasion as the œsophageal growth. Some 13 cases of two primary independent malignant neoplasms are on record. The duodenal growth here was considerably larger than usual. It is the rule in these cases to have no biliary obstruction owing to the softness of the growth, but there are exceptions.

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Teratologia is the name of a new medical quarterly published in Edinburgh. Dr. J. W. Ballantyne is the editor. It will treat exclusively of the pathology of the fetus.

USE OF THE ABDOMINAL DRAINAGE-TUBE DETERMINED BY BACTERIOLOGICAL EXAMINATION.

Read Before the Philadelphia Academy of Surgery, June 4, 1894.

By C. B. Penrose, M. D.,
Philadelphia.

The subject of drainage in abdominal surgery is one about which there is still great difference of opinion, though this difference is much less than it was only a few years ago. Some operators never used drainage at all after any operations, and yet obtained exceedingly good results; while others obtained equal results, and their statistics showed that they employed drainage in a proportion of their cases, which varied, according to the individual taste of the operator, from 5 or 10 per cent. to 75 per cent.

The general advice given by the advocates of drainage was "when in doubt, drain." It was this element of doubt which caused the diversity of practice. The doubting operators drained the most. Everything which increases our knowledge in regard to the facts which determine drainage diminishes our doubts and brings about more uniformity of practice.

We drain the abdomen for two reasons —for hemorrhage and for septic material. As the experience of the operator increases and his skill in enucleating tumors becomes greater he has less hemorrhage and, other things being equal, he drains less. Our methods of controlling hemorrhage in abdominal operations are better than they were a few years ago, the Trendelenburg posture enabling us to check bleeding from small vessels in the bottom of the pelvis, which before the introduction of this position required drainage. The operator who enucleates pelvic tumors with two fingers and closes the abdomen without seeing what he has done will necessarily have much more doubt in regard to hemorrhage and will use the drainage-tube much more frequently than the operator who inspects the field of enucleation before closing the abdomen.

The second reason for drainage is the septic character of the material which escapes or is retained in the abdomen. Knowledge in regard to this fact is of great value in deciding about drainage in any case.

During the past winter, at the University Hospital, an immediate bacteriological examination has been made of the contents of every tubal or ovarian tumor which was ruptured during removal. And the report of the pathologist in regard to the septic or aseptic character of the contents has determined my decision in regard to the use of the drainage-tube.

I, unfortunately, have no record of the total number of cases in which such examinations have been made; but the results have been exceedingly satisfactory, for out of a series of 46 cœliotomies, in which drainage was used but three or four times for hemorrhage, and only once because the microscope showed the material which escaped into the abdomen to be septic, there has been no case of peritonitis or sepsis.

The tubal contents in most cases of salpingitis are sterile. Shauta (*Archiv. für Gynecologie*, 1893, No. 44) reports 192 cases of salpingitis, in 144 of which the contents of the tubes were sterile, in 33 there were gonococci, and in 15 streptococci or staphylococci.

Before I began to use this method of bacteriological examination I inserted a drainage-tube in every case of tubal and ovarian abscess where the contents escaped into the peritoneum. Now I neither irrigate nor use the drainage-tube unless the microscope shows these contents to be septic. The presence of gonococci in small numbers does not necessitate drainage. Recently the value of this bacteriological examination was

illustrated by two cases operated on consecutively. Each woman had a tubo-ovarian abscess, caused by sepsis at labor. In each case the abscess was ruptured during removal, and the pelvis filled with pus. In the first the pus was found to be sterile, and I closed the abdomen without irrigation or drainage. In the second one pus contained streptococci and staphylococci and coli commune. Consequently, the pelvis was thoroughly washed out and drained.

Both women recovered without peritonitis or sepsis, though the convalescence of the first was very much easier than that of the second.

The examinations have been made for me by Dr. Beyea. Cover-glass preparations of the material to be examined are made and are fixed in the flame of an alcohol lamp, and stained with carbol-fuchsin. The microscopic examination is made with a Leitz 1-12 immersion lens.

The examination is quickly and easily made, and I think that no operating-room is completely equipped without facilities for such bacteriological examinations. They furnish us with scientific data from which we can determine the propriety of an important surgical procedure, which otherwise depends upon the whim or prejudice of the operator.

Word Blindness.—Bianchi (*British Medical Journal*) reports a case in a printer aged 71, who had suffered for several months from attacks of vertigo, with loss of consciousness, and from fits. In a recent more severe attack, the right side was temporarily paralyzed, and he lost his speech. On admission the sight of the left eye was considerably limited, and he had right hemianopsia. There was no motor loss except in the left face. There was marked disturbance of speech. He understands, but cannot answer. Reading is impossible. He recognizes one or more letters in a word, but constructs a word quite unlike that before him (paralexia). He writes well from dictation, but spontaneous writing is quite inaccurate, and he cannot copy. Hallucinations are present. At the necropsy the following lesions were found in the right hemisphere: (1) A small focus of softening in the outer part of the lenticular ganglion; (2) a lesion in the white matter at the foot of first frontal convolution; and (3) an old lesion in the corpus callosum in connection with the splenium, and extending into the præcuneus. In the left hemisphere there was a focus of disease in connection with the angular gyrus, destroying especially the gray matter of the first temporal sulcus (hinder part), and another one involving the white matter of the angular gyrus, and stretching to the posterior horn, but sparing the first and second temporal convolutions. It is probable that a part of the verbal acoustic centre is in relation with the verbal visual centre, and that thus the destruction of this latter centre produced not only a simple alexia. The failure of the recollection pictures for speech hindered the motor functions for speech and writing, and since the patient was blind for written words, he was also amnesic for spoken as well as written words.

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Ergot for the Night Sweats of Phthisis.—Goldendach (*British Medical Journal*) thinks that the night sweats of consumptives are not simply due to fever, and that their real cause has not yet been fully explained. Many remedies have been recommended for them—quinine, acetate of lead, atropine, hyoscin, brandy, rubbing the body before sleep, or using the powder composed of starch, talc, and salicylic acid. Most of these Goldendach has tried and found wanting. On considering the part probably played by the vasomotor nerves, he determined to try the effect of ergot against night sweats, and in most cases found the result very satisfactory. He usually gives one or two 5 grain doses of powdered ergot before bed time, and the cases are few in which this remedy is found quite useless. He has, moreover, never seen any harm result.

SOCIETY REPORTS.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING MAY 18, 1894.

The 297th regular meeting was called to order by the President, Dr. George J. Preston, President *pro tem.*

Dr. W. H. Welch read a very interesting and instructive paper on THE IMPORTANCE AND SOME OF THE RESULTS OF SYSTEMATIC BACTERIOLOGICAL EXAMINATIONS AT AUTOPSIES.

Dr. C. W. Mitchell followed with a paper on "RICKETS," viz.:

The belief that the importance of rickets is generally underestimated by American physicians has led me to bring this subject before the Society. Errors widely prevail as to the frequency of its occurrence and the direct bearing it has upon the course of many diseases of children. While it prevails most widely in the densely populated cities of Europe, it is yearly becoming more frequent here.

Numerous theories have been offered as to its etiology and while there is probably some truth in each of them, they teach us on the whole that there is probably nothing specific in the nature of rickets, that it is a perversion of the normal metabolism of the body and that any cause of general malnutrition may give rise to it. Probably the most common cause of it is improper feeding and I should like to emphasize the fact that it occurs among rich as well as poor children. If looked for with care it will be found to affect the child of the millionaire as well as the bow-legged negro of the back alley.

Unfortunately riches will not provide mother's milk. The breast-fed offspring of the poor woman is less apt to suffer from rickets than the artificially-fed child of the society woman. Of course I do not mean to state that the gross deformities are so frequently found among the children of the rich, because when they begin to show themselves they are properly treated, but I do believe that changes in the chest wall, which are the most constant and dangerous of all the signs of rickets, are frequently overlooked among the children of the well-to-do.

Whenever the changes in the chest wall are marked they lessen the breathing force of the patient to so great an extent as to cause simple catarrhal inflammations of the respiratory organs to be attended by grave dangers. So in cases so mild as to be overlooked unless the child be stripped, there is apt to occur dangerous complications on the part of the lungs, in the course of diseases which in perfectly healthy children need excite no anxiety.

In rachitic children simple bronchitis is attended by danger because the respiratory movements being weakened the course of the disease is prolonged and broncho-pneumonia results. So too in measles, whooping cough, etc., the presence of rachitic changes renders the prognosis always uncertain. Most textbooks state that rickets occurs most commonly from the sixth to eighteenth month but recent investigations show that many cases begin earlier.

As deformity of the chest is the earliest of all signs we should have the child—in all cases of bad nutrition—stripped from time to time and carefully examine all the bony structures.

Care should be had not to keep the child upon any one article of food to the exclusion of others for too long. The greatest care and attention should be given to the food. When rickets actually occurs the child should be kept in the sunlight as much as possible. Phosphorus, cod liver oil, iron and arsenic are of value medicinally, and Dr. Abel, of Johns Hopkins University, has recently demonstrated that lime water, hitherto thought to be inert, may exercise great influence on animal metabolism.

In conclusion I wish to emphasize the following points:

1. Deformity of the chest is the earliest as well as the most formidable manifestation of the disease.

2. Rachitis is probably not a specific disease but results from any of the causes of malnutrition.

3. It is not only preventable but may

be promptly arrested when early recognized.

4. Be on the lookout for rickets in private as well as in dispensary practice.

Dr. Wm. Osler said he was always interested in a discussion of rickets for it was very remarkable how often common cases of this disease were overlooked by physicians. It is certainly increasing in this country.

H. O. Reik, M. D.,
Secretary.

CORRESPONDENCE.

OUR NEW ASYLUM.

Editor Maryland Medical Journal.

Dear Sir:—As was noted in the Journal, the last Legislature passed an act authorizing the erection of a new asylum for the indigent insane of this State. Governor Brown, whose intelligent interests and active efforts contributed largely to the success of the measure, has appointed a board of managers, and it is hoped that the work of construction will shortly begin. The medical profession of this State is, or at least should be, deeply interested in this matter. They know more about the needs of the insane than any other class of our citizens, and there rests upon the profession a certain responsibility to see that the trust is administered in the best possible manner. The whole idea of asylum construction and management has undergone a most radical change in the past decade. Formerly, as we know only too well, buildings were constructed for the safe keeping of crazy people ; these unfortunates were crowded into jails and poorhouses, and when humanity demanded some more suitable place of confinement the asylum-jail was the outcome of the demand. We can thankfully say that all this is changed now, and the insane are properly regarded as sick people and are treated as such. Thus in asylum construction we have passed from the jail epoch through the asylum-jail period to the hospital era. In an exceedingly interesting and suggestive paper read before the last meeting of the American Medico-Psychological Association, Dr. Weir Mitchell calls attention to certain shortcomings in our American system of asylum management, and offers many valuable suggestions. This criticism and these suggestions are endorsed by letters from a number of the most prominent specialists throughout the country. (The paper of Dr. Mitchell is such an important contribution to the subject that I would advise any one interested in asylum management to read the whole article which appears in the July number of the *Journal of Nervous and Mental Diseases.*)

The following, in brief, are some of the points discussed: 1. The asylum should be within easy reach of a city for obvious reasons, and this would apply with especial force to Maryland. 2. There should be a farm of several hundred acres of good land. The mistake is often made of purchasing a "poor farm" in both senses of the word. One of the strongest points in the modern treatment of the insane is the necessity for employment, and if possible out door employment. (Witness the good results obtained at Wernersville, Pa., and elsewhere, under this system.) 3. Great stress is laid by Dr. Mitchell, and by all the specialists whose opinions were asked, upon the necessity of separating the general and medical management. It is conceded that in this country scientific study and treatment of the insane has fallen far below what it should be, mainly because the superintendent has his time occupied with merely detail work; he has to purchase supplies, look after the farm, supervise the attendants and a thousand like things which leave him little or no time for the careful study of the cases in his wards. This work is assigned usually to his assistant, who is perhaps a young man of little or no experience. The plan suggested, the plan that is very generally adopted in Continental institutions, is to have a general superintendent who shall live in the asylum, and whose duty it will be to see to the running of the institution, and a medical superintendent who shall visit the asylum every day, and whose duty shall be wholly medical. In this manner

alone is it possible to have a specialist who can devote sufficient time to the study of the individual cases. The cost would be very little greater, and it is more than probable that the increased percentage of cures would more than counterbalance any additional cost. 4. A resident physician, or several, if necessary, appointed in the same manner as the general hospital appointments are made. 5. Nurses trained for this particular work. It is perfectly feasible to develop a training school at the asylum where the nurses can be taught how to manage this class of cases. 6. As regards hospital construction, there can be no doubt that the cottage plan is the best. This provides for a central executive building with detached wards where suitable classification of patients can be made. This plan would also suit us best since we are not able to put up all our buildings now.

I have been led into writing a longer letter than I had intended, but it is a matter of importance that we start right, that our foundations be laid broad enough to permit us to carry on our work in accord with the most advanced ideas of the treatment of the insane. To further this it is very necessary that the profession in the State and city interest themselves in this important work, and aid it by their encouragement, advice and influence. Very sincerely,

GEORGE J. PRESTON, M. D.

819 N. Charles St.

MEDICAL PROGRESS.

ANTISEPSIS IN OBSTETRIC PRACTICE.—Henrotay (*British Medical Journal*) and others have drawn up an important report on this subject, with a view to future legislation regarding midwives. Amongst other conclusions, they urge that puerperal infection is usually transmitted by contact of the genital tract of the patient with a virus conveyed by the hands, instruments, or linen. The special germs (streptococci, staphylococci) as a rule come from some other puerperal patient, but may also be traced to cases of anthrax, erysipelas, or simple furunculus. The atmosphere, as an infecting agent, plays no part save in exceptional instances, where scrupulous antisepsis has been practiced. Autoinfection is rare and of secondary importance; the report further shows that the term in question is not similarly defined by different authorities. Elevation of temperature in childbed is as a rule a sign of infection at the moment of delivery. When for twenty-four or more hours after delivery the temperature rises over 100.5°, the case requires serious attention. On the above opinions rules for treatment are laid down in the report. The minimum of requirements is set down as including (1) perfect cleanliness of all sheets, blankets, and utensils used for the patient; (2) disinfection of the hands of the physician or midwife and of all instruments before use; (3) disinfection of the external organs.

* * *

THE USES AND MISUSES OF ANESTHETICS.—Dr. Frederick W. Silk considers in the London *Lancet* the proper uses of anesthetics, which are for the relief of pain during operation; for the lessening of shock and for the perfection of technique. The misuses are first by persons who take chloroform for its pleasant effects and contract the habit; second, the too frequent use of anesthetics for small operations; third, care in the choice of an anesthetic; fourth, an incompetent administrator; and fifth, the danger of prolonged anesthesia.

* * *

THE EFFECT OF TIME ON THE MEMORY OF MOVEMENT.—Dr. Schneider, of Jurieff (Dorpat), acting on the advice of Professor Ciz, has made a series of observations, which are reported in the London *Lancet*, on the effect of the lapse of time upon the memory of movements. These are published as a graduation dissertation (in Russian). The method adopted was to fix the right arm of an intelligent person, so that only the wrist could move, and to tie a pencil to the forefinger, so that a curved line could be marked on a piece of paper ruled in millimetres. The person was blindfolded and requested to draw a line, and after a

definite interval of time he was asked to draw another as nearly as possible of similar length; the length of this was compared with that of the first line, and the error noted. Altogether 4000 experiments were made with three individuals, the mean error after half a minute being $\frac{1}{29}$; after 2 minutes, $\frac{1}{28}$; after 6 minutes, $\frac{1}{24}$; after 10 minutes, $\frac{1}{21}$; and after 15 minutes, $\frac{1}{17}$ of the length of the original stroke, thus showing that the memory of movements grows rapidly less and less accurate even during the first few succeeding minutes.

* * *

Glycerine Injections as an Oxytocic.—Pelzer (*British Medical Journal*) read a communication on this subject at a recent meeting of the Cologne Obstetrical Society. He had collected 28 cases, including 19 in his own experience. Glycerine was used 18 times for induction of premature labor; in 15 of these cases the pelvis was narrowed, in 2 there was Bright's disease, and in 1 placenta previa. To stimulate uterine action at term glycerine was injected in 7 cases of simple atony, in 2 of placenta previa, and in 1 for some other complication. The pains came on after an average interval of two hours following the injection. Eight to ten hours elapsed before complete dilatation of the os, or a longer space of time in cases of contracted pelvis. Two of the mothers died, both from severe eclampsia; the fetus was putrid in both cases. One child required craniotomy on account of its great size. Three children died from placenta previa and strangulation by the funis. One, hardly 32 weeks old, died a quarter of an hour after birth. Only in one case could the violence of the pains be a possible cause of the death of the child. The gylcerine had done its duty. Pelzer, however, deprecates injudicious zeal about this method; 30 to 50 cubic centimetres, not 100 cubic centimetres, are sufficient for injection. The method is not suitable for cases of eclampsia and placenta previa, except the lateral variety, where the placenta can be avoided.—Geuer (*ibid.*) read notes of three cases of induction of premature labor by injection of glycerine, in all of which both mother and child were saved. The first two mothers were over 32, with contracted pelves; craniotomy had been performed in previous labors. The third case was an instance of bad eclampsia; 40 grammes of glycerine were injected, the os being at the time uncontracted; there was edema, with much albuminuria. Forty hours later a healthy living child was born.

* * *

Railway Spine.—The great increase in railway travel has brought into prominence certain surgical injuries which assume great importance. These Dr. H. J. Saunders classifies, in the *Columbia Medical Journal*, into those in which some visible mischief is done, and those where no apparent harm has been sustained at the time of the accident. It is for the latter class of cases that railways are so often sued. The means of diagnosis are:

1. The absence of any apparent injury to the spine adequate to cause disorganization or derangement of the cord.
2. The time of development of the disability.
3. The nature of the symptoms.
4. The history of the patient, both personal and family.
5. Certain diagnostic symptoms to be discovered by careful examination of the organs of the body, such as changes in the fundus of the eye, the reaction of degeneration, lessened or exaggerated tendon reflexes, etc.

Too much care cannot be exercised in giving the prognosis in these cases.

* * *

Puberty in Cold Countries.—Grusdeff (*British Medical Journal*) has collected statistics of 10,000 women, all inhabitants of European Russia. The result shows that the period appears comparatively late, as was already generally suspected. It is seen earliest in women German by race—that is, on an average, at 15.14 years, or sixteen short of three months. The averages in years for the other races are: Poles, 15.33; Jewesses, 15.40; true Russians, 15.75; Esthonians and Lapps, Finno-Sclavonic races, 16.19; and true Finns, 16.27. The social condition had

a great influence on the appearance of the period. In the privileged classes the average age was 14.87, in town-women 15.33, in peasant women 16.15. It is distinctly later in North than in Middle Russian, and in Middle than in South Russian peasant women. The average for the whole of Russia is 15.74, but a few exceptionally early cases are included in Grusdeff's statistics—namely, 1 in the ninth year, 4 in the tenth, 31 in the eleventh, and 244 in the twelfth. In 3 menstruation was delayed till the age of twenty-four, in 1 till thirty-two. As might be expected from the above statistics, the highest figure out of the 10,000 is at the sixteenth year, namely, 2012.

* * *

Chronic Inflammation of the Seminal Vesicles.—Chronic inflammation of the seminal vesicles is not always easy to make out, as it has symptoms like other inflammations of the urethra. Dr. Gardner W. Allen, in the *Medical News*, says that there may be a chronic urethral discharge, with shreds in the urine, or there may be vesical irritability with frequent micturition. In many cases there is some disturbance of the sexual function. In considering this subject the author offers the following suggestions :

1. The fluid in a distended vesicle, subjected to pressure, would escape at the point of least resistance, which would be the natural outlet, no matter how tortuous, unless the wall of the vesicle were ruptured by violence. Simple pressure on such a blind sac would seem better than an attempt to strip the vesicle down toward the duct.

2. The slow and unsatisfactory progress of a few cases may be due to the difficulty of emptying such portions of the vesicle which may in these cases be the chief seat of disease.

3. In some cases the ampulla of the vas deferens may alone be affected, when the stripping process would be easy and effective.

4. Disease of the vas deferens may possibly be of more importance than that of the vesicle itself, obstructing as it does the direct road from the testicle.

5. Simple massage of the vesicles may play an important part in the treatment.

* * *

Acute Supra-Glottic Edema without Apparent Cause.—Dr. John H. Pryor reports in the New York *Medical Record* a case of acute supra-glottic edema without apparent cause in a man aged thirty, who was vigorous and healthy. The attack was so sudden and so evanescent that it was hard to account for, and it was attributed either to vasomotor conditions or to temporary stoppage of the lymph-channels, the former probably being the cause. Dr. Pryor brings out the following points of clinical value. 1. The absence of any known causative agency and constitutional symptoms. 2. The extent of edema, which may occur without marked dyspnea. 3. The peculiar character of the voice. 4. The marked benefit of prompt treatment without scarification. 5. The possibility of the case belonging to a group of obscure clinical manifestations known as angio-neurotic edema or allied vasomotor curiosities.

* * *

Hysterical Gangrene. — Ehrl, (*British Medical Journal*) reports the following case in a girl, aged 18. Since her sixth year there had occurred regularly in the late autumn a reddening of small portions of the skin, followed by the formation of bullæ, which burst and healed. Three years ago the affection attacked the cheek, and was accompanied by anesthesia of half the face. Two months before admission the skin affection recurred, but under a different form ; small portions of the skin on the right cheek became blackish in color and sloughed. Similar lesions occurred on the left arm. On admission, besides the scars, there were blackish sloughs on the back of the left hand. Three months later the patient again came under observation with localized gangrene of the skin, and on several subsequent occasions she had relapses. Later there was limitation of the visual fields and also hysterical aphonia. No organic cause could be found for the disease. The diagnosis of its hysterical nature

was based on the anesthesia, visual disturbance, aphonia, ovarian hyperesthesia, etc., as well as the duration, recurrence, and changing character of the disease. There was no evidence that the lesions resulted from self-inflicted wounds. Subsequently a sister of this patient came under treatment with right hemianesthesia. Similar patches of redness followed by localized gangrene also appeared on the left breast, and later on the cheeks, in this case.

* * *

Primary Confusional Insanity.—In the *British Medical Journal* Séglas contributes a clinical study of this disease (*confusion mentale primitive*). The symptoms are both mental and bodily. Among the former must be placed bewilderment, astonishment and hebetude, or the expression is inert and stupid. The patient is lost in his responses to questions and appears to be out of touch with persons and things round about him. He has difficulty in finding words for his ideas and in understanding what is said to him. His thoughts are slow, and there is difficulty in fixing his attention. He is distracted by persistent dreamings. He is in a state of doubt and uncertainty, and his perception and imagination are defective. The disease is not due to disturbances in the elementary sensations, but in the psychological interpretation of these sensations. The memory is weakened. Accurate recollections may, as it were, be forced upon him, but he is unable voluntarily to recall events. The same alteration takes place in regard to voluntary movements, which are hesitating, maladroit, etc. In slight cases this inability of action is greatly complained of. Sometimes intervals are present when the patient recognizes the confusion in his ideas. Sometimes there are delusions of a melancholic type, which are changeable and incoherent. Hallucinations may be present. Sudden impulsiveness may occur, when violence either to himself or another may be done. The docility, however, is usually striking, especially to some people, who may thus manage the patient easily. In the bodily symptoms there is general weakness, exhaustion, and loss of flesh. The pupils may be unequal. The cataleptic state may supervene. Insomnia is almost constant. Two forms are recognized, the asthenic and hallucinatory. Sometimes the bodily symptoms predominate, and the forms may then be classed as cachectic, typhoid and meningeal. The onset of the disease is usually rapid. It lasts on an average from four to six months. It may end in recovery, chronic dementia, or death. It is the only mental disease besides general paralysis which may cause death. The prognosis is worse than in mania or melancholia. The more complicated and changing the form the worse the prognosis. Slighter forms must be distinguished from melancholia. The physiognomy is quite different from mania. In early general paralysis there is no real confusion of ideas, but progressive dementia. Traumatism, physical and moral, infective disease, excesses, etc., are important occasional causes. Heredity is of less significance than usual. The bodily condition must be improved ; alkaline bromides are to be avoided. If due to auto-intoxication, efforts at elimination should be made. Moral treatment is important. Confinement to an asylum should be delayed as long as possible.

* * *

Apoplexy and Temperature Elevation.—Dr. Charles L. Dana has studied forty-five cases of intra-cranial hemorrhage and has recorded in the *American Journal of the Medical Sciences* his observations on apoplexy in its relation to the temperature of the body, with a consideration of the question of heat centres. His statistics show that in fatal cases, at least, there is, on the first day after the stroke, a rise of rectal temperature; on the second day the temperature falls a little. In acute softening there is rarely disturbance of temperature, while on the second day there is a slight rise. In massive intra-cranial hemorrhages the temperature on the paralyzed side was always somewhat higher than upon the sound side, while in cases of acute softening there was practically no difference between the temperature of the two sides. After an

elaborate study of his cases he draws the following lengthy conclusions :

1. All intra-cranial hemorrhages, whatever their lesion, are much more apt to be accompanied with immediate disturbances of temperature than are necrotic processes from embolism and thrombosis. These temperature disturbances in hemorrhages are, in rare cases, a sudden initial fall; then in almost all cases except where the lesion is small, there is within a day or two a rise of temperature of from one to three degrees. On the other hand, in acute softening this initial fall and early rise do not occur unless the process is very extensive or involves the pons.

2. In apoplexy due to hemorrhage, the temperature is greater upon the paralyzed side than on the normal, the difference averaging about one degree. In acute softening this unilateral difference of temperature does not occur or is extremely slight.

3. The rise of temperature due to apoplectic lesions depends more upon the extent and nature of the lesion than upon its location. Lesions of a hemorrhagic character in the cortex, however, are especially apt to cause a rise of temperature. Lesions in the pons also either of hemorrhagic or softening character, almost uniformly cause a rise of temperature.

4. There is as yet no clinical evidence that lesions of the basal ganglia or the parts about them cause temperature rises on account of destruction of certain thermic centres; in other words, the clinical and pathological evidence of thermic centres in the human brain, aside from the parts mentioned, is yet inadequate.

5. Finally, I would specially impress upon you the great value, from a diagnostic point of view, of a careful study of the temperature changes after apoplectic strokes. The temperature should be observed on each side of the body, in the rectum, also, if possible. With data thus obtained one can, I feel sure, gain much more positive evidence as to the nature of the lesion in these cases, and I have repeatedly been able to satisfy myself, in my clinical work, of the nature of the lesion by means of the methods referred to. I do not believe that with the help of the numerous factors which we now have in aiding our diagnosis there are many cases of apoplexy in which it is difficult to make a diagnosis. The old-time tabulation of differential points in diagnosis between hemorrhage and acute softening still remains of value. We need, and must use, all the helps possible; but if we, in addition to other methods, carefully apply the thermometric, I am sure we can reach vastly more satisfactory results.

* * *

Functional Nervous Disturbances. —The nature and management of functional nervous disturbances are very difficult to understand. Dr. Charles G. Stockton, of Buffalo, in an address before the New York Academy of Medicine, which is reported in the *American Medico-Surgical Bulletin*, says that the successful management of functional disorders of the stomach includes not only proper dietetic management, but also the discovery and removal of the cause. The etiological fact is often quite remote. He holds: 1. That functional gastric disorders generally arise from influences outside of the stomach. 2. That these causes are usually to be found in some reflex irritation or toxemia. 3. That among the latter, syphilis occasionally has a place, which apparently has not been noticed hitherto. 4. That structural changes in the stomach are not so much the causes of as they are the result of gastric disturbance. 5. That the successful treatment of these affections must include the removal of an often unsuspected exciting cause.

* * *

Operations for Piles.—Dr. J. S. Wight describes in the *Medical and Surgical Reporter* a new operation for piles which, in his opinion, has the following advantages: 1. Easy and rapid work: 2. Absence of hemorrhage; 3. Complete excision of the piles; 4. The suture-ligatures take care of themselves; 5. Repair with a small quantity of scar-tissue; 6. Quick convalesence; 7. Good results.

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See Publishers' Department, Page 316.

BALTIMORE, AUGUST 4, 1894.

The Management of Fevers.

DR. J. BURNEY YEO, of King's College, London, has taken up in a scientific manner in the *American Journal of the Medical Sciences* the management of fevers, and particularly of typhoid fever. He had long since advocated the antiseptic or antitoxic idea in the treatment of pulmonary phthisis and he wishes to carry out the same ideas with respect to typhoid and other fevers. In typhoid fever the specific organism produces within the body ptomaines which exercise their toxic action on the glandular, muscular and nervous tissues, causing fever. Whatever the theory of fever may be, it is a question if the same substances which arrest the growth and development of these micro-organisms outside of the body may not be so modified as to destroy the organisms within the body and thus reduce and remove fever. We certainly possess agents which are capable of controlling more or less the pyrogenic effect of these infective organisms and Dr. Yeo thinks from these considerations the following conclusions may be drawn:

1. That our recently acquired knowledge as to the nature and causes of specific fevers requires a modification in the therapeutic conceptions and indications applied to their management.

2. That the antagonism of pyrogenic and other poisons produced within the body by the micro-organisms which give rise to these fevers is the most essential therapeutic indication to be applied in their treatment.

His first attempts in the treatment of typhoid fever were made with sulphurous acid and he thinks the results were very marked. He also has long been impressed with the great efficacy of free chlorine as an antiseptic agent, or rather a mixture known as euchlorine, which contains free chlorine as obtained by the action of hydrochloric acid on powdered potassium chlorate. He therefore has determined to give this mixture and to give quinine internally as a general antiseptic. This mixture he makes in the following manner:

Into a twelve-ounce bottle put thirty grains of powdered potassic chlorate, and pour on this sixty minims of strong hydrochloric acid. A greenish-yellow gas is at once liberated. Close the bottle with a cork and agitate the mixture gently until the bottle is filled with gas, then pour water into the bottle, little by little, closing the bottle and shaking well at each addition, until the bottle is filled.

We have in this solution several antiseptic agents all in a *state of solution*, and readily absorbable, which is one of its great merits over antiseptics not in solution; free chlorine, hydrochloric acid, potassium chlorate, and probably one or two by-products. In twelve ounces of this solution twenty-four to thirty-six grains of quinine are dissolved, and some syrup of orange-peel added to make it more agreeable to take; and of this, to adults, one ounce may be given every two, three, or four hours, according to the severity of the case.

He has used this method in all cases under his care in King's College Hospital with excellent results. When used he finds a remarkable cleaning of the mouth and tongue; a rapid removal of the putrefactive odor of the feces; a depression of the temperature; a shortened fever; very little disturbance of the patient by the fever poison, and a rapid and complete convalescence with no trouble-

some sequelæ. The reduction of the temperature is not so rapid nor accompanied by sweating as is usual with the ordinary antipyretics as there is not sufficient quinine in the mixture to cause this result. Arguing in the same direction guaiacol carbonate has been very effectively used both in tuberculosis and typhoid fever.

The use of intestinal antisepsis early in the disease to restrain the putrèfactive changes which take place there is the foundation of the treatment. In the same way Bouchard used calomel when there was no diarrhea, with washing out of the intestines with naphtholated water. The digestive and absorptive activity in these cases is extremely small, which is often caused by a too free administration of milk, forming hard cheesy masses in the stomach. Do not give more milk than can be absorbed and give all food very dilute.

Alcoholic stimulants may be given toward the end of the most severe cases but as a rule they are given too early and the milder cases do better without any. Infusion of coffee is an excellent and effective stimulant which has been neglected. Depressing antipyretics should not be used. He does not advocate the cold bath. Dr. Yeo's aim was to present a therapeutic idea in harmony with our present pathological knowledge.

* * *

Cooling Drinks.

THIS is the season when the loss of large amounts of water from the body, principally by skin respiration, causes great dryness of the mouth and fauces and extreme thirst, particularly in those who lead an active life and exercise in the warm weather. The amount of liquid that is poured into a much abused and long-suffering stomach is appalling. There is no doubt, however, that the ingestion of liquids at this season is absolutely necessary and it is only when the wrong liquid is used or taken in excess that harm is done.

However pleasant to the palate alcoholics may be, every one not a total abstainer knows by experience that they are not cooling but cause an increased flow of the perspiration at once. Even water, if taken too rapidly, causes profuse sweating. The various soft drinks and soda waters are cooling at first but, if too sweet, increase rather than allay thirst.

Probably one of the best thirst quenchers is iced tea. In general, too much tea is supposed to react on the nerves on account of its stimulating alkaloid, called theine; but it is generally admitted that in iced tea there is less of the noxious ingredients present than in hot tea, consequently greater quantities of the former, particularly when diluted with water, may be taken. Applications of cold water to the surface of the body, as sponging, will often quench thirst. Slow drinking also does more good than rapid swallowing, but the latter seems more grateful to one very thirsty.

It is astonishing how many persons continue to drink alcoholics in summer with the idea that they are cooling. Any one will admit that the gourmand likes wines for their taste, while the toper likes wine and whiskey principally for their effects, but neither if asked could honestly answer that wine, whiskey or any mixed drink containing alcohol makes one feel cooler.

* * *

Care of the Insane.

THE recent address by Dr. Weir Mitchell on the care of the insane in asylums is full of sound practical truths and now that Maryland will soon have an additional hospital for the insane, care should be taken that the dangers to which Dr. Mitchell alludes and the good methods which he advocates receive proper consideration. These facts Dr. Preston has most clearly pointed out in his timely letter which appears in this issue. An insane asylum is no longer to be thought of merely as a place where the insane are confined, but as a hospital where attempts are to be made to cure the curable cases, to improve the condition of those amenable to such improvement and where the incurable may be fairly comfortable and have pleasant surroundings. It is not only a great advance in medicine but from a philanthropic standpoint is a step forward when the insane are no longer regarded simply as an incurable class to be huddled together and confined in uninhabitable cells.

* * *

THE Eighth International Congress of Hygiene and Demography promises to be a very enormous affair. Already 593 papers have been promised to the hygienic section alone. There is always danger of too much haste when so many papers are on the programme.

MEDICAL ITEMS.

The warm weather has driven many physicians from the city.

The German Hospital of Philadelphia is erecting an additional building.

The University of the State of Missouri, situated at Columbia, is a very wealthy institution and well equipped in every department.

The American Association of Obstetricians and Gynecologists will hold its seventh annual meeting at Toronto, September 19, 20 and 21, 1894.

The International Ophthalmological Congress will hold its eighth meeting in Edinburgh in August. Many Americans usually attend. Dr. Argyll Robertson is the president.

Professor Pettenkofer has resigned his position in the University of Munich. It is reported this step has been taken because of his opposition to the carrying out of sanitary measures based on the observations and views of Koch.

Dr. W. J. Hardman, of Ann Arbor, Michigan, will deliver the President's address before the American Electro-Therapeutic Association at its fourth annual meeting, to be held at the New York Academy of Medicine, September 25, 26 and 27, 1894.

The first prosecution under the new medical practice act took place last Saturday, when Dr. Wm. F. Lockwood, the secretary of the board, and Hon. Archibald H. Taylor, its attorney, charged Dr. E. R. Johnston, in charge of the Western Maryland Home, at Cumberland, with practicing medicine without having registered according to law. Dr. Johnston gave bail and demanded a jury trial, which will be looked for with interest by those who wish the new law upheld.

Dr. Joseph Pagani, one of the best-known physicians in Boston, died recently. He was born in Borgomanero, Italy, in 1836. In 1863 he was graduated from the University of Pavia. He came to America in 1865, and after a short stay in New York went to Boston. For his kindness to Brazilian subjects he received in 1883 from Dom Pedro the decoration of Chevalier de Buenos Ayres. In 1892 he was made Cazique and Baron Roxley in the Aryan peerage of Russia. He was a distinguished member of several medical societies.

The Twenty-Second Annual Meeting of the American Public Health Association, which will be held at Montreal next September, promises to be a very large affair. Members from all professions and other callings are on the list and the subjects are varied enough to be interesting to all. The railroads have reduced their rates and extensive preparations have been made to insure a successful meeting.

A prize of 10,000 rubles ($5000) is offered by Count Orloff-Davidoff for the discovery of a certain cure or preventive of cattle plague. The efficacy of the remedy is to be proved by the same standard as those known to science as protective against small-pox, anthrax, etc. The award of the prize is in the hands of the Curator of the Imperial Institute of Experimental Medicine of St. Petersburg, acting on the advice of a committee of experts selected for the purpose. The competition is open to the whole world with the exception of active members of the above-named institute. The description of the proposed remedy must be clear and complete; it must be sent in, under the ordinary conditions as to concealment of identity on the part of the author, on or before January 1, 1897. The award of the prize will be made January 1, 1899. If no remedy satisfies the committee, a further competition will take place, and the award made on January 1, 1902.

The District of Columbia Commissioners have added two important amendments to the building regulations. The first prohibits the stabling of horses above the ground floor and the text of the other is as follows:

"No building shall hereafter be erected or altered on any residence street of the District of Columbia to exceed in height above the sidewalk the width of the street; and in no case to exceed ninety feet in height. No building shall be erected or altered on business streets, as defined in the building regulations, to a greater height than the width of the street abutting its front; provided, that no such building shall exceed one hundred and ten feet in height in any case; provided, further, that no spires, towers, and domes may be erected to a greater height than the limit hereinbefore prescribed when approved by the Commissioners."

The exclusion of light and air by tall buildings was probably a factor in this new regulation.

Book Reviews.

Transactions of the Fifteenth Annual Meeting of the American Laryngological Association. Held in the city of New York, May 22, 23 and 24, 1893. New York. D. Appleton & Company, 1894.

This volume contains a number of papers, none of which are very remarkable. Dr. Delavan argues against the withholding of reports of operations for the relief of cancer of the throat. Dr. Samuel Johnston showed specimens of large polypi having their origin in the nasal passages and growing posteriorly to a great size.

Nuovo Metodo di Cura della Tubercolosi Polmonare. Per le Dottore Carasso Giovanni Michele, Tenente Collonnello Medico, Direttore dell' Ospedale Militare di Genova. Roma, 1894.

This little brochure contains an account of a new method of treating pulmonary consumption and one which has been noticed in the medical journals for some time past. The author has abundant faith in his methods and cites a number of cases which have gone on to cure under his care. The book opens with a short description of the methods hitherto used. First comes the old way of treating that disease with its results; then in a dramatic manner is set forth the so-called Koch cure and how he made it known at the Tenth International Medical Congress at Berlin. Then the author takes up such therapeutic agents as creosote and its derivatives; injections; inhalations; and lastly he draws conclusions from all these means and methods that all are useless and that consumption is still incurable. In Part II he takes up the importance of inhalations and the antiseptic power of these inhalations and then he describes his own "new method" of curing consumption. He has a peculiarly constructed inhaler by which the patient gets full power of the substance inhaled. In this he puts essence of peppermint, which the patient inhales four or five times in the course of the day. The patient closes the mouth around the end of the inhaler and also closes the nose and takes eight or ten deep inspirations so that the solution is drawn in and brought in contact with the mucous membrane of the bronchi and lungs. The patient also takes internally an alcoholic solution of creosote containing glycerine, chloroform and essence of peppermint. To this is added an abundant diet; plenty of fresh, rich milk, sterilized, if necessary, meat, and whatever the patient can stand. Following these methods the author claims to have cured cases far advanced in consumption. While every one may not pin their faith to the high-colored reports of an enthusiastic Italian, still the method of treatment is certainly simple and is worth trying.

REPRINTS, ETC., RECEIVED.

Tennessee Medical College, Knoxville. Announcement. 1894-95.

Albany Medical College. Catalogue 1893-94 and Announcement 1894-95.

Errors in School Books. Second Competition. Boston: Pope Manufacturing Co., 1894.

Baltimore University School of Medicine. Announcement and Catalogue. Session 1894-95.

Annual Announcement and Catalogue of the Baltimore Medical College. Session 1894-95.

College of Physicians and Surgeons. Baltimore, Md. Annual Announcement and Catalogue. 1894-95.

Thirteenth Annual Announcement and Catalogue of the Woman's Medical College of Baltimore. Session 1894-95.

Life and Healing. A Segment of Spiritonomy. By Holmes W. Merton. Published by the Author, 212 Columbus Avenue, Boston, Mass.

Appendicitis Obliterans. By N. Senn, M. D., Ph. D., LL. D., Chicago, etc. Reprint from the *Journal of the American Medical Association.*

Ophthalmia Neonatorum; Contraction of Eyelids; Glaucoma; Grattage for Granular Lids. By L. Webster Fox, M. D., etc. Reprint from the *Medical Bulletin.*

Alumni Oration delivered before the Alumni Association of the Medico-Chirurgical College of Philadelphia. By Hon. Charles Emory Smith, Philadelphia. Reprint from the *Medical Bulletin.*

Hydrotherapy at Saratoga. A Treatise on Natural Mineral Waters. By J. A. Irwin, M. D., etc. One volume, 12mo, pp. 270. Price, Paper, 50 cents; Extra Cloth, $1.00. New York: The Cassell Publishing Company, 1894.

Immediate Capsulotomy following the Removal of Cataract. By L. Webster Fox, M. D., Professor of Ophthalmology in the Medico-Chirurgical College of Philadelphia. Reprint from the *Medical Bulletin.*

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NOTES.

ANTIPYONINE is indicated in hyperemia of the conjunctiva and phlyctenular conjunctivitis.

*

PICROTOXINE, 1-40 gr. at bedtime, is claimed to be an efficient remedy for night-sweats of phthisis.

*

DR. E. HOLLAND calls attention to the fact that the taste of chloral hydrate is effectively masked by lemonade. Two or three drachms of the syrup should be placed in a tumbler with about two ounces of water. If to this is added about two ounces or so of gaseous (bottled) lemonade, the mixture may be drunk at leisure, and the soporific action of the drug is in no way impaired.

*

A CONTEMPORARY uses as a cardiac tonic this formula in a tablet:

Morphia . . .	gr. 1-12
Strychnia . . .	gr. 1-134
Atropine . . .	gr. 1-250
Caffeine . . .	gr. 1-67.

*

AND now some faithful follower and admirer of the late Brown-Sequard proposes to name the new elixir Sequardine. He thinks that most of the elixirs are valuable on account of the phosphorus in them and he is eliminating a glycero phosphate that will contain the combined virtues of all other such elixirs.

READING NOTICES.

Hæmoferrum.—The President of the Kansas State Homeopathic Medical Society, Dr. E. K. Thompson, McPherson, Kansas, states: "I am using Hæmoferrum (Stearns') with most beneficial results and think it is the best preparation of iron on the market.

*

Peacock's Bromides.—I have given Peacock's Bromides a thorough trial, and have since then invariably prescribed it in preference to other preparations of its kind. During my trip across the ocean, I gave it to several passengers who suffered a great deal from sea-sickness, with very beneficial results. J. Wilmoth, Ph. D., M. D., New Orleans, La.

*

Bromidia.—A physician writes of this remedy as follows: I have found Bromidia excellent in delirium tremens accompanied by insomnia, also in the delirium of typhoid, and in bronchitis with neurasthenia following influenza. In a case of chronic nephritis where all kinds of hypnotics, anti-neuralgics and analgesics had failed to give relief, Bromidia, in doses of a teaspoonful morning and evening, gave relief at once; and in a few days effected a complete cure. After such encouraging results, I am sure Bromidia has a brilliant future before it.

*

Typhoid Fever.—Dr. Joseph D. Rush reports favorably in *Virginia Medical Monthly* two cases of typhoid fever, where results were obtained from the exhibition of Antikamnia and Salol. 1st. Female, æt. 24, married. Fever at end of seventh day reached 105° F. Calomel, sodium and quinia having failed, then gave

℞ Antikamnia.
Salol . . . . . aa. ʒ ss
M.—Make into twelve capsules. Sig.—
One every three hours.

This treatment maintained for twelve days secured convalescence. Alcoholic baths to the spinal column once a day, the diet being boiled milk and tea.

2d Male, æt. 13. Temperature 105°, same treatment, same result. He concludes that salol as an internal antiseptic combined with the antipyretic qualities of antikamnia, promises all that can be desired in the treatment of low and continued fevers with bowel complications.

"Antikamnia and Salol Tablets" are put up in exactly the dosage as given above, each tablet containing 2½ gr. Antikamnia and 2½ gr. Salol, by the Antikamnia Chemical Co., St. Louis, Mo., which please specify.

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ORIGINAL ARTICLES.

GUN-SHOT WOUNDS OF THE SMALL INTESTINES; LAPAROTOMY; ENTERORRHAPHY—CURE.

Read Before the Medical and Chirurgical Faculty of Maryland, April, 1894.

By Randolph Winslow, A. M., M. D.,
Professor of Anatomy and Clinical Surgery in the University of Maryland.

Patrick Dorsey, aged 60, white, married, was admitted to University Hospital on December 22, 1893, at 1.30 A. M. About 6.30 P. M., the previous evening, he was shot with a pistol by a watchman on the Baltimore & Ohio Railroad, and was first taken to his home, and thence was brought to the Hospital. He was a spare but healthy man and was not suffering from shock when admitted. The ball entered the right iliac region, about four inches to the inner side of the right anterior superior spinous process of the ilium, and about the same distance above Poupart's ligament.

On the morning of the 22d, his temperature was 101°, pulse 104. Was seen by me about 12 noon. The wound was small, with discolored edges. The patient was at once put under chloroform, and an incision made through the track of the bullet, which led into the peritoneal cavity. Considerable free dark blood was found in the abdominal cavity, which was flushed out with hot water. The intestines were examined and some adherent clots removed, and four wounds leading into the lumen of the bowel were found. Some fecal and foreign bodies were also found in the peritoneal cavity. The wounds were all situated in the ilium, and three of these were close together, whilst the fourth and largest was eight to twelve inches distant—two of the wounds were separated from each other by only a small bridge of intestinal wall. Three of the wounds were quite small and required four to six sutures to close them; the fourth was nearly horizontal in direction and about an inch in length, and required ten to twelve sutures for its closure.

The edges of this large wound were widely everted, and I feared that the bowel would be unduly narrowed if it was sutured longitudinally, so it was brought together transversely to the long axis of the bowel, Lembert sutures being employed for all the intestinal wounds. As there was some free bleeding from behind the peritoneum, the abdominal incision was not sutured, but was packed with iodoform gauze. As the bullet could be felt under the skin of the buttock, it was known that only a small portion of the peritoneal cavity had been traversed, and that only a limited portion of the intestines were likely to have been injured, hence a median laparotomy was thought unnecessary. The patient was somewhat shocked by the operation, but rallied promptly. Some vomiting followed as a result of the anesthetic.

For several days the patient was not

allowed any nourishment, and then rectal enemata were given. Subsequently small quantities of milk were allowed by the mouth every two hours. On the evening of the 22d, his temperature fell to 99⅖°, pulse rose to 120, respiration 24. The temperature remained near 100° during the first week. On December 28, the gauze was removed, and the patient chloroformed and the cut edges of the muscles sutured with buried sutures, and the incision closed. The wounds healed nicely, and the temperature remained nearly normal until January 4, 1894, when it suddenly rose to 102⅕°, falling as suddenly to 99°. The temperature rose again to 102° and there was found an induration of tissues in the iliac fossa. An abscess was supposed to be forming, and an incision was made in the right iliac fossa, through the muscles and iliac fascia. Some purulent fluid escaped and a free hemorrhage occurred. As it was night and sufficient light could not be obtained, the bleeding vessel could not be secured, and the wound was packed with gauze, which arrested the bleeding. The missile was also extracted at this time ; it was scarred and had passed through the ilium and lodged under the skin of the buttock. The temperature fell promptly after this incision.

On January 10, 1894, a pulsating lump developed in the right iliac fossa, and he was chloroformed for the fourth time, and a free curved incision made along and above Poupart's ligament, in order to expose the deep circumflex iliac artery, which was ligated, and no further trouble occurred. Considerable blood had been extravasated behind the peritoneum, and a lot of disintegrated clots were removed. From this time the progress of the patient toward recovery was uneventful. Owing to a milk diet and prolonged recumbency, an obstinate constipation supervened, and it became necessary to give him strong purgatives, before a movement was obtained. He was not allowed to eat solid food for about a month, after which he ceased to be troubled with constipation, and he rapidly gained flesh. He was practically well from the intestinal wounds in a few days, but on account of the large wound made in securing the circumflex iliac artery, he was not entirely healed until March.

In view of the great mortality of penetrating gun-shot wounds of the abdomen, I feel justified in bringing this case to the notice of the Medical and Chirurgical Faculty, and I take special pleasure in so doing, as it is the first case of recovery which has occurred in the State of Maryland after laparotomy and suture of the intestinal lesions. The mortality of gun-shot wounds of both intestines, as tabulated by surgeon Geo. A. Otis in the Medical and Surgical History of the War of the Rebellion, is 80.3 per cent., and almost all of the recoveries followed wounds of the large intestine. Dr. Otis says further, "that in wounds of the small intestine of any magnitude, the pathological evidence of recoveries achieved by the unaided effort of nature, even through the establishment of a preternatural anus, is limited to a very few instances, of which none are absolutely unequivocal." Previous to 1882 penetrating wounds of the abdomen were treated by the administration of opium to prevent peristalsis, and by abstinence from food, but the result of this method of treatment is shown in a mortality of 80.3 per cent.

About forty years ago the elder Gross, after a series of elaborate experiments upon animals, advocated opening the belly and suturing the intestinal wounds, but his views were far in advance of his day and his suggestions went unheeded. It was not until 1881 that the attention of the medical profession was again challenged, by the illustrious J. Marion Sims, to the necessity of treating these fatal injuries radically by laparotomy and suture, and it is to Dr. Sims that we are indebted for pointing out the proper procedure in these serious cases. In 1882 Dr. Kinloch, of Charleston, performed laparotomy and sutured five wounds of the intestine and mesentery, but unfortunately overlooked two additional wounds and the patient died. Lloyd, of England, operated unsuccessfully in 1883, the patient having peritonitis at the time of the operation. In

1884 Professor Kocher, of Berne, opened the abdomen for a pistol wound of the stomach, sutured the lesion in the viscus and the patient recovered.

Following close upon this achievement came the brilliant success of Dr. William T. Bull, of New York, who, in November, 1884, performed laparotomy and sutured seven wounds in the small intestine and saved his patient. Since then numerous operations have been reported, and a fair percentage of recoveries have resulted. Dr. A. B. Miles, of New Orleans, reported recently thirteen operations with five recoveries, and Dr. Stimson, of New York, five operations with three recoveries. As these cases when left to nature almost invariably terminate fatally, I think the principle of operative interference has been fully established. One is no longer obliged to apologize for the performance of laparotomy in these cases, but is under the necessity of defending himself if he fails to give his patient the benefit of an operation.

In my opinion all wounds which are likely to have penetrated the abdomen ought to be explored by an incision, and if found to have entered the peritoneal cavity, laparotomy should be performed at once and the injuries repaired if possible. The operation should be done at the earliest practicable moment without waiting for the occurrence of symptoms of fecal extravasation. Even small wounds should be treated in the same manner, as fatal injuries may result from small pistol wounds. Do not wait for symptoms of intestinal injury, but operate at once. When symptoms of extravasation arise, it will be too late to operate. In most cases after determining that the missile has entered the peritoneal cavity, it will be best to perform a median laparotomy, as greater access is thereby gained for the systematic exploration of the viscera, but not unfrequently it may be best to make the laparotomy at the site of the bullet wound, if only a small portion of the cavity has been traversed, as in the case reported above. When wounds are found in the intestines they should be closed with fine sterilized silk by means of the Lembert suture or some of its modifications. Any bleeding point in the mesentery should be ligated. The patient subsequently should be kept perfectly quiet, and no food allowed by the mouth for several days, alimentation being carried on by means of rectal enemata. After three or four days, milk and liquid diet may be taken by the mouth, and in two or three weeks the patient may gradually resume a diet of solid food.

RHEUMATIC CONJUNCTIVITIS.

By A. L. Hodgdon, M. D.,
Baltimore.

WAS called to see Mrs. J. and found intense inflammation of the right conjunctiva with radiating pains through the head ; ordered :

℞.—Sodii Borat. . . grs. x
Aq. Extr. Opii . grs. j
Aquæ Camphor . ʒ ij
Aquæ . . . ʒ j

M. et Sig. A few drops in the eye three times a day.

I also gave internally small doses of the sulphate of morphia to quiet the pain. The above not proving very effective, I ordered in its place :

℞.—Zinc Sulphat. . . gr. j
Atropiæ Sulphat. . gr. j
Aquæ Rosæ . ʒ iv

M. et Sig. A few drops in the eye three times a day.

Suspecting a rheumatic element present in the disease, I added to the treatment colchicin, gr. $\frac{1}{150}$, every three hours, and during the treatment the patient improved rapidly. As soon as some nausea was produced by the colchicin I diminished the dose to gr. $\frac{1}{300}$ every three hours. I had treated this same patient three months before for acute articular rheumatism.

A CASE OF PYEMIA DUE TO APPENDICITIS.

Read Before the Philadelphia Academy of Surgery,
June 4, 1894.

By Richard H. Harte, M. D.,
Surgeon to the Pennsylvania and Episcopal Hospitals.

The history of the case I wish to present to you this evening is as follows: A. C., aged twenty-five years, a weaver by occupation, was admitted to the medical wards of the Episcopal Hospital, May 9, 1894, at the request of his medical attendant, Dr. Ferguson, supposing the man to be suffering from abscess of the liver.

On admission the following facts were elicited, which I have copied from the Resident's meagre notes: *Family history*, negative. *Previous history:* Enjoyed good health, although not especially robust; about three years ago recalls having a short illness ushered in by a chill, the prominent symptoms of which were sharp, cramp-like pains referred to the lower third of the abdomen; was confined to bed for a week. (This was undoubtedly an attack of appendicitis). *Present attack:* States that he was feeling perfectly well up to about two weeks ago, when he was awakened with sharp pains in the right iliac fossa, and in the course of the morning they were followed by a pronounced chill, succeeded by sweating; through the day he felt nauseated, and in the evening vomited.

During the interval of two weeks from the time of his first attack until his admission into the hospital, he had always once in twenty-four hours, and sometimes oftener, a decided chill followed by profuse sweating; pain, referred in the right iliac, umbilical and hypochondriac regions, was almost continuous; the bowels were watery, and moved daily; the patient was confined to bed and growing weaker.

After his admission into the medical wards all his symptoms were referred to the region of the liver, over which there was distinct tenderness. The daily chill and high temperature (106° F.) naturally led my colleague, Dr. Morris, on the medical side, to suspect abscess of the liver, and he transferred the case to the surgical wards for operation.

On the day after his transfer to the surgical wards I found the case very much as above stated, the right hypochondriac region being tender on pressure, liver area increased. On examining the case in the ward before operation, I exposed but a small portion of the abdomen and noticed a distinct eruption, which I supposed was due to the vigorous use of a scrubbing brush. The case was then taken to the operating-room and etherized, and on a more careful examination of the abdomen under an anesthetic, I found the eruption, which I had first supposed was due to the bichloride and friction, to be pretty generally distributed over the entire trunk, and in appearance was not unlike the eruption of typhus fever, or, in other words, a distinctly morbilliform eruption. The history at that time in my possession was rather negative, and I decided not to operate until more definite data could be obtained. On the following day I saw the physician under whose care he had been, and with my colleagues, Drs. Deaver, Neilson, and Morris, decided to make an exploratory incision over the region of the liver. The patient was etherized, and an incision corresponding to the right semi-lunar line gave a free opportunity to explore the surface of the liver, which appeared normal. An exploration with an aspirating needle failed to reveal any purulent collections. The region of the appendix was explored through the abdominal wound, suspecting that possibly it might be the seat of the trouble; but with the hand carried down over the

liver to the right iliac fossa, no evidence of trouble was apparent.

After the operation the chills seemed to be less severe, not being so frequent as before, and the temperature not rising so high. The external wound closed quickly, and no symptoms relative to the operation were manifest. The next chill was four days after the operation, and did not rise nearly to within two degrees of the height of the previous one. The next chill did not appear until the fifth day, although the patient was gradually growing weaker, and died on the tenth day after the operation. After the second chill he began to expectorate bloody mucus, sometimes a cupful of blood being expectorated during the twenty-four hours.

A post-mortem examination revealed the liver slightly enlarged and filled with a large number of metastatic abscesses, the principal pus collection and largest abscess being in the left lobe. The appendix was entirely destroyed, and its position occupied by the small pus cavity holding about three drachms of pus. The cecum for several inches beyond its attachment to the appendix was gangrenous. There were some septic deposits in the lungs, although no distinct infarcts were to be found. The reason I ascribed for the liver being affected, which is usually a secondary affection coming under the general circulation, is that the materies morbi coming from the appendix immediately entered the portal circulation—superior mesenteric vein—and consequently the first deposit would naturally be found in the liver.

The post-mortem here distinctly revealed a case of pyemia, the primary cause of infection arising from the appendix. One peculiar feature in the case was the eruption, which was more or less misleading, although eruptions in suppurative fever, or pyemia, have long been recognized, and are spoken of by Braidwood in his exhaustive treatise on that disease.

My object in briefly reporting this case to-night is that I think it of no little interest (without wishing to go into the subject of pyemia, which is so familiar to all the Fellows of the Society), throwing as it does more light upon the much mooted subject of appendicitis, and again, adding its weight to the testimony that the above mentioned disease is strictly a surgical affection rather than a medical one ; for I feel certain that had the true condition of affairs been recognized at the onset of the attack, the ultimate termination might have been different.

LARGE DOSES OF IODIDE OF POTASSIUM IN BRAIN TUMORS.

By J. Ewing Mears, M. D.,
Philadelphia.

I SAW this patient in consultation with Dr. Charles A. Groff. The patient, aged seven years, exhibited the symptoms of a brain tumor which was thought might be operable. Eye-examination by Dr. Oliver confirmed the diagnosis, but located the tumor in the posterior portion of the base of the brain. In view of the result obtained by this examination, it was deemed advisable to try the curative effects of large doses of iodide of potassium, given in gradually increasing quantities; 103 grains daily were finally administered with decided amelioration of the symptoms and without any ill-effects from the use of the drug.

The history of the case is given by Dr. Groff as follows:

Elsie E., aged seven years. First came under observation in December, 1892. Complaining of severe headaches, recurring almost daily and lasting for hours, during which the child was compelled to lie down until sleep came to her relief, apparently as the result of exhaustion. This had existed for two years, gradually becoming worse.

Family history: Father, painter by trade, was never sick in his life, never

had syphilis; mother strong and healthy; no knowledge of having been sick.

There is a younger child, now less than two years old, born with equina varus, which difficulty has been almost entirely corrected by the use of splints and bandages.

Examination of patient at the date mentioned developed at once defective vision and slight paralysis of the right side, especially of the lower extremity. She was put upon bromide of potassium and was sent to an ophthalmic surgeon, who treated her for some time, but no improvement in vision was noted, nor were the headaches lessened. She was sent to a second ophthalmic surgeon, who diagnosed a brain-tumor and said that nothing could be done for her.

In February, 1893, she was put upon iodide of potassium, six grains daily, which was gradually increased until August, when she was taking thirty-three grains daily. At this time the headaches had lessened in frequency, the condition of paralysis remained stationary, but the difficulty in vision seemed to be increasing.

I saw the patient on August 7, in consultation. He agreed with me in the diagnosis, also in the treatment, and advised the increase of the iodide of potassium. This was done, ten grains being added to the daily dose every two weeks, until the child was taking one-hundred and three grains daily. This point was reached in November, 1893, and was continued until February, 1894, when the amount was decreased to 90 grains daily, which quantity she has been taking up to the present time. As the remedy was increased, there was evident improvement in the condition of the patient. The headaches were much lighter in character and happening with markedly increasing intervals, until now they have practically ceased. The paralysis is much less marked, and Dr. Chas. A. Oliver, who has made repeated examinations, says her vision is improving.

Appended is the report of Dr. Oliver showing changes occurring under the administration of the large doses of iodide of potassium.

Ophthalmic examination, September 26, 1893. Neuro-retinitis of soft edematous type, the left nerve-head being the more swollen; both the retinal arteries and the veins reduced in size, especially the latter; the left iris fails to respond to the strongest light stimulus; the right iris seems to respond at times; vision of right eye reduced to a doubtful light-perception in all portions of a considerably contracted field; vision in the left eye still further reduced to a faint recognition of the light from the temporal side. These ocular conditions, with a general history of the child, gave a diagnosis of brain-tumor with enlargement of the ventricles; the supposed neoplasm being probably tubercular in character and situated in the posterior portion of the base of the brain (cerebellar?).

On October 18, 1893, there appeared to develop a doubtful left homonymous hemianopsia; the nerve-heads shrinking. No tubercular deposits could be recognized in any part of the fundus of either eye.

The irides gradually and interchangeably bettered in their reaction, the fields of light perception obtained both subjectively by the patient's recognition of the position of the light and at times objectively by the movement of the irides, until at present writing they seem to respond much more freely than when the patient was first seen. Vision, which is reduced to perception of light, varies extremely upon different examinations, though relatively it is slightly better than when the patient was first seen; the examination at the last visit reversing the comparative areas of recognition in the right and left fields. Ophthalmoscopically, the nerve-heads are considerably shrunken and have become markedly atrophic.

A Russian proposes to use the iodide of rubidium instead of the iodide of potassium, the advantage of the former being lack of disagreeable taste and the fact that iodism is not caused. The dose is the same as the iodide of potassium.

DISLOCATION

BETWEEN THE SECOND AND THIRD CERVICAL VERTEBRÆ IN A HORSE, WITHOUT ANY PARALYSIS.

By A. W. Clement, V. S.,
Baltimore.

A BAY three-quarter thoroughbred gelding fell in jumping a fence in the hunting field, landing on his knees and at the same time striking his head and twisting his neck. The horse got up immediately and he was ridden home. The rider says that he persisted in carrying his head low but went along all right. He did not attempt to make him trot.

It was some three weeks after the accident occurred before I saw the case. The conditions then presented were as follows: The crown of the occiput was in a straight line from the withers or most prominent superior spinous processes of the dorsal vertebræ. There was a convex deviation from the straight line on the right side of about two inches, extending over the second and third cervical vertebræ and a corresponding concavity on the left side. The point of the nose and mouth was carried to the right of a straight line through the face about one and one-half inches. The head could be moved laterally on the neck about eighteen inches and up and down about as usual. The animal could turn his body to the left as well as ever but was somewhat awkward in turning to the right. The end of the third vertebræ could be distinctly felt jutting out beyond or to the side of the second vertebræ. The animal was given me for experimentation, and it was determined to operate, though with no hope of success, as adhesive inflammation had gone so far as to preclude any chance of reduction, even were such a thing possible at first. However, the animal was cast, chloroformed, and extreme extension with great pressure tried without any success. The second and third vertebræ were then completely exposed along the greater curvature of the dislocation. It was found there was fracture of the side of body of the vertebræ as well as dislocation, so that the pieces of bone could be pressed with the finger. It was then decided that any further efforts at operating would be useless and probably destroy the appearance of the specimen for anatomical purposes. I decided to close up the wound and allow the animal to live for a while for purposes of observation. This was done and the animal is now doing duty at light driving in the country near here. Later on the animal will be destroyed and the specimen exhibited to the medical profession. Several physicians have already seen the case and any who may be interested are quite welcome to examine the animal and to attend the autopsy, due notice of which, should the editor desire, will be given in this JOURNAL.

ALEXANDER'S OPERATION.—Dr. Paul F. Mundé gives, in the New York *Medical Record*, his ten years' experience with Alexander's operation for shortening the round ligaments of the uterus. He says:

In conclusion, while I do not undervalue the difficulties of the operation and the uncertainties which will always be attached to it, I must still assert my unqualified belief in it, in properly selected cases, in preference to the other dangerous and, as regards permanent results, no more certain, operations of ventral fixation and intra-peritoneal shortening of the ligaments.

* * *

CESAREAN SECTION.—In difficult labors it is often a question between craniotomy and Cesarean section, and Dr. J. H. Carstens, who takes a very broad view of the matter, thus gives his opinion on the subject in the *American Journal of Obstetrics:*

1. In certain cases with antero-posterior diameter of three inches craniotomy is justifiable.

2. With an antero-posterior diameter of less than three inches Cesarean section should be performed.

3. In the latter case sometimes the classical, sometimes the Porro-Cesarean section should be preferred.

CROUP AND DIPHTHERIA.

From Advance Proof Sheets of the Transactions of the Medical Society of the State of Pennsylvania.

By B. H. Detweiler, M. D.,
Williamsport, Pa.

Mr. President, Ladies and Gentlemen: The pathology and treatment of membranous croup has been encroached upon by bacteriologists to such an extent that it is no longer considered a disease, *sui generis*, but only an exudate, the result of diphtheria caused by the Klebs-Loeffler bacillus. Dr. Wilson, in his exhaustive article on Laryngitis, in the Theory and Practice of Medicine, Pepper, 1894, says: "So overwhelming is the preponderance of the unquestionably diphtheritic cases, that many competent observers regard all cases as of that nature—an extreme view that finds ample justification in the fact that no criteria have yet been established by which the differential diagnosis between diphtheritic pseudo-membranous laryngitis and the so-called non-contagious membranous croup of the dualist can be made by the clinician during life, or by the pathologist after death, save only by the presence or absence in the exudate of the Klebs-Loeffler bacillus. In both the symptoms are the same, the course and termination of the attack are not different. Physicians who look upon every case of pseudo-membranous laryngitis as a probable case of diphtheria, enjoy the practical advantage of erring; if err, they do upon the safe side."

The celebrated Drs. White and Keen, in their late surgery, endorse the same theory. Were the theory correct in practice, the course of the physician would be clear; but to the older physician the demonstration of the unity of these two diseases is not as yet complete. They are two distinct diseases; membranous croup was one of our terrible diseases, blanching the cheek of every mother upon the slightest whistling cough of her darlings, before the more dreaded name of diphtheria was a household word. In 1856, I saw my first case of membranous croup, and it proved fatal. In 1858, the first case of diphtheria came under my observation, which then became epidemic.

The course of these diseases was widely different, but when the larnyx became involved, their termination was the same—death. Dr. O'Dwyer says that one child in ten, with well marked symptoms of laryngeal diphtheria, recovers under medical treatment—Dr. Wilson says under all forms of treatment the mortality ranges from 60 to 80 per cent., and that all cases should be treated alike, as for diphtheria. It is the fact of this large mortality which I especially wish to press upon your consideration.

I do not consider it necessary to call your attention to the anatomical construction of the larnyx, nor the distribution of the squamous epithelium upon the lining tissues of the pharynx and mouth, and the ciliated upon the vocal cords; nor that these epithelial cells determine whether the exudation be croupous or diphtheritic. This is the point that should be fully considered, and upon which the duality of these diseases depends.

Dr. Wilson says, "ciliated exudation is termed croupous and squamous diphtheritic; hence, the German pathologists are correct in speaking of this process as a croupous diphtheritic inflammation." Croupous inflammation is in all cases the exudation that involves the vocal cords from their anatomical construction, of ciliated instead of squamous epithelium. If this exudation be exposed to the Klebs-Loeffler bacillus, there is no question of the attack being diphtheria; but should it be simply inflammation of the vocal cords, why not treat it as any other

inflammation? Why wait till the exudation becomes formed? if diphtheritic, the mortality is so great that it is almost hopeless; and if not, why allow this exudate to become so firm that it is equally hopeless?

The cause of death is mechanical obstruction in one case, and in the other, mechanical obstruction with septic poisoning, due to specific microbes. The patient will be a croupy child—probably its second night with a harsh, rough cough and high fever. The preceding night it had a few paroxysms of croup, was restless, with some fever; during the day it was apparently well. There is no exudation in the throat and nose, nor any enlarged cervical or submaxillary glands. This is a case of acute laryngitis of childhood; but in the morning you find instead of convalescence, a short hacking cough with continued fever, and you are not so sure of your diagnosis. If there are bacilli of Klebs-Lœffler in the trachea below the point of observation, the child will die; but if the thickening of the vocal cords by this croupous exudation is simply inflammatory why not treat it as for inflammation?

Twelve hours will determine whether you can restore the child to its mother's arms or have it die the slow death of strangulation, or modified by the happy intubation of O'Dwyer with its record of decimation. It is cyanosed—breathing with the clavicular space indrawn and its throat clasped with its tiny hands to avert strangulation. You place two or three leeches on the larynx with ¼ grain doses of calomel every half hour till the characteristic spinach stools are voided; after full depletion of four or five hours, you check the bleeding points, apply a blister, and the cough will diminish, the cyanosis disappear, and in a couple of days the child will be convalescent.

During this treatment, inhalation of steam with lime water will be grateful and curative. The first case that I treated in this manner was in 1867. The distinguished physician who called me in consultation stated the case was hopeless, and said the boy must die. He was two years old. As a *dernier resort*, I applied two leeches, and in five hours applied a blister. He convalesced rapidly. I have had many such cases in these years—one especially, when the consulting physician insisted on tracheotomy, but after depletion, neither intubation nor tracheotomy were required. Another when I saw the boy of two years at 6 P. M. on the evening of the second day, after a croupy night. At 9 the same evening I found him cyanosed — and so much oppressed, they could not hold him in his crib. I applied two leeches, and followed it by a blister. In 48 hours he was convalescent.

Should this exudate, even, be diphtheria located below the point of observation, the child may recover, but will probably die—as the treatment beyond the abstraction of blood is what is considered proper by many who pride themselves on their success in treating this terrible fatal disease; but if it is not surely diphtheria, and there is a bare possibility of its being a croupous exudation on the vocal cords, why not use the depleting and revulsive treatment, instead of relying upon the treatment that has a standard mortality of 60 to 80 per cent., and rely upon removing the immediate danger of strangulation by intubation or tracheotomy? I select my cases, and in doing so, have not lost a single case of membranous croup, nor have had an intubation.

My mortuary record of diphtheritic exudation extending into the larynx is no better than my compeers'. I am persuaded it is of importance that the recognition of the duality of these diseases be made early, and that it is not good practice to err, if err they do, by treating all cases of croup on the so-called safe side of diphtheria with its terrible mortality record, and that it is the duty of every practitioner to diagnose *early* every case of croup; if diphtheritic, treat it accordingly; if membranous give it the advantage of depletion and revulsives, by the prompt administration of calomel in quarter grain doses, every half hour, till the characteristic spinach stools are secured, inhalation of steam from lime water, which dissolves the croupous ex-

udate upon the vocal cords, which cause the disease; and prompt depletion for four or five hours by leeching, and followed immediately by a cantharidal blister, which treatment will result in certain and speedy cure. Without the help of intubation or tracheotomy, I have followed this course since 1867 without the loss of a single patient.

MEDICAL PROGRESS.

OPERATION FOR OLD UTERINE PERINEAL LACERATIONS.—Dr. W. Gill Wylie, in examining a number of graduates for the position of interne at Bellevue Hospital, asked a question which suggested to him to write an article on the best method of operating on old lacerations of the perineum, especially those associated with the formation of a rectocele, and displacement of the uterus, which he reported to the *American Journal of Obstetrics*. His conclusions, which are quite lengthy, are :

1. As a rule, when the perineum is completely severed so that the fecal matter escapes passively, the position of the uterus is not affected.

2. The outer or lower part of the perineum may be torn to a considerable extent and the position of the uterus will not be affected.

3. When the inner or upper part of the perineum is torn or overstretched and relaxed, prolapse of the posterior and anterior vaginal walls will take place, and in time the uterus is retroverted, prolapsed, and may be forced out of the pelvis.

4. The explanation is that when that part of the perineum formed by the fibres of the levator ani and the pelvic fascia where they encircle and are attached to the lower end of the vagina and anus, is torn apart, the lower end of the vagina and the upper part of the anus are loosened so that they are not held up and elevated when intra-abdominal force is exerted, as in straining at stool ; both are forced out through the vaginal outlet, and they pull and drag down the uterus, and in time may result in hernia of the pelvic organs.

5. In operating to restore the parts we should aim to reunite the separated edges of the levator ani and the pelvic fascia, and fix them to and in front of the lower end of the rectum and the upper part of the anus, and thus prevent the fecal matter from forcing forward the anterior wall of the rectum and putting on the stretch the posterior wall of the vagina, and in this way displacing the uterus downward and throwing the fundus backward between the utero-sacral ligament, etc.

6. This can be done efficiently only by denuding the retracted tissues on either side of the rectocele and uniting them over and in front of the rectocele. As the most important laceration is within the ostium vaginæ, to reach these tissues the operation must be within the vagina ; and to secure good apposition and to avoid dragging down and adding to the tension, most of the sutures should be passed within the vagina from side to side, so as to unite the separated edges of the pubo-coccygeus muscle and pelvic fascia in front and over the upper end of the anus and the lower end of the rectum, in such a way as to deflect the fecal matter, as it descends to the lower end of the rectum, back out through the anus, and thus effectually prevent the reformation of the rectocele with its results on the vagina and the uterus.

7. As a rule, when in an old laceration there is a rectocele with retroversion, etc., there will be found an abnormal condition of the anus and lower end of the rectum. There are nearly always hemorrhoids, fissures, or erosions of the anus or rectum, and not infrequently the sphincter ani is abnormally developed, contracted, and irritable, and on this account it is often necessary to remove these conditions to effect a cure of the case. And it is always best to freely dilate the rectum before sewing up the lacerated vagina.

8. Even where there is complete procidentia, with the cervix or whole uterus out of the vaginal opening, this operation can be made to effect a permanent cure in most cases by combining with it amputation of the cervix uteri, and inserting the sutures so as to shorten up the portion of the stump left in the

vagina and, as it were, tie up the upper end of the vagina to the upper part of the cervix uteri at the os internum; or, in those cases where there is retroversion, by doing Alexander's operation to shorten the round ligaments, and thus prevent the long axis of the uterus becoming parallel with the axis of the inferior strait of the pelvis and acting as a wedge to be pushed out, by every effort at stool, through the mouth of the vagina and reproducing the procidentia.

Excluding cases of enlargement from intractable or incurable disease or new growths, I do not believe in removing the uterus on account of extreme prolapse or procidentia, for, with rare exceptions, they can be cured by the above operations.

* * *

A New Method of Enterorrhaphy.—Dr. B. B. Cates has performed a number of experiments upon the primæ viæ of the lower animals in the search after a new method in enterorrhaphy and submits, in the *University Medical Magazine*, as a result of these experiments, the following observations:

1. Perforations occurring at site of operation when making invagination are more liable to be near mesenteric attachment.

2. Nothnagel's test was corroborated three times.

3. When using hydrogen gas in locating perforation and obstruction in the primæ viæ, we must be sure there is no occlusion in the rectum, such as hardened feces, etc.

4. In excision of cecum, when ligatures are applied to mesentery to stop hemorrhage, there is liability of including the arterial supply of bowel not in area of cut off gut.

5. That it is not absolutely necessary to apply a ligature to mesenteric arteries in the cut off gut, simply compressing with hemostatic forceps and tearing the mesentery from its attachment to cut off gut being sufficient.

6. That in making lateral anastomosis or end-to-end union of bowel while a slight scarification of the opposed serosæ would, as first pointed out by Davis, of Birmingham, hasten the adhesion and consequent definite union of coaptated parts, this may be ignored where the adherent surfaces are backed up by sutures.

7. That where the coaptated parts are reinforced by sutures, such as catgut, a frame-work is formed for the plastic exudate, which is quickly thrown out, thereby shutting off any avenue for the intestinal contents to escape into abdominal cavity.

8. Wherever sutures are applied to serosæ they will be covered with plastic exudate within twelve to forty-eight hours.

9. That buttons offer many advantages as sutures over plates in making approximation of bowels by lateral anastomosis. Firstly, time, which is such an important factor in these operations, is greatly reduced. Secondly, they do not slip about and thus annoy and vex the surgeon. Thirdly, the approximation surface can be reduced or increased at the surgeon's will. Fourthly, they act as splints to the bowel and bring the coaptated parts into closer union, and the ectropium, which is sometimes troublesome to the surgeon, is easily controlled; and lastly, the button, when it frees itself by pressure-atrophy, will, on account of its small size, easily pass through the ileo-cecal fissure.

10. Wherever the fistulous communication between the bowel is over an inch in length, a button should be inserted every three-quarters of an inch to prevent ectropium and to bring bowel into closer union.

11. That anastomosis as a surgical procedure offers better ulterior results in restoring the fecal circulation than end-to-end union of bowel, because in the former method, when the opening is long enough, it is not followed by so great traumatic stenosis as in end-to-end union.

12. That in making this anastomosis my button is superior to plates. And therefore I offer it to the surgeons of America (in lieu of plates), to whose hands its future usefulness as a surgical procedure is consigned.

13. That whatever procedure is adopted, it is safer to back up or reinforce

the circumference of fistulous communication in coaptated bowels with sutures of fine aseptic silk, which will encapsulate itself, or catgut, which will be ultimately absorbed, the Dupuytren or the Dieffenbach suture being the quickest and easiest applied.

* * *

Treatment of Periuterine Inflammation.—Dr. J. Foster Scott, of Washington, D. C., thus gives his ideas on the treatment of periuterine inflammation, in the *American Journal of Obstetrics* :

If the condition originates from a septic endometritis, as it so frequently does, the uterus should be curetted, washed out, and a gauze drain introduced up to the fundus.

In the acute or chronic forms, where you do not suspect suppuration to have occurred, the patient should be kept at absolute rest in bed, and have morning and evening hot douches, prolonged for fifteen to twenty minutes. If the bowels are not filled with impacted feces it is advisable to keep the patient well under the influence of opiates to quiet peristaltic action. Painting over a large surface of the lower abdomen with iodine should be tried, and, though I have never seen it done, I should be in favor of applying six or eight leeches to the portio vaginalis. Ice-cold applications are better than hot poultices ; the latter, in my estimation, favor the growth of septic organisms and hasten suppuration, which might be averted by cold. If there is a gonorrheal history the utmost trouble should be taken to prevent its ravages by antiseptics applied to the inner surfaces of the uterus even, if it has spread there. Diet and tonics, of course, will be attended to ; pain will be met with morphia suppositories and opiates; and the temperature will be kept down by sponging with cold water and alcohol, and giving aconite and antipyretics with judgment. The treatment is practically the same whether the condition is pelvic peritonitis, cellulitis, ovaritis, or salpingitis. Celiotomy will be required if suppuration has occurred, and in cases of tubercular peritonitis the abdomen should be opened and flushed with hot water freely. Rarely is it advisable to remove the products of suppuration or effusion by an incision from the vagina or by tapping.

* * *

Bassini's Operation for Hernia in Young Children.—Dr. Samuel E. Milliken reports to the New York *Medical Record* two herniotomies in a child under five years old in which he used Bassini's method, from which he concluded as follows :

1. When any difficulty is met with in the mechanical treatment the radical operation should be performed even in young children.

2. If, after six months or a year, the truss has been steadily worn, and there still exists a flabby condition of the inguinal region, the operation is also indicated.

3. The risk of operating on children, where strict asepsis is observed, is little, if any, more than in adults.

4. The chances for a radical cure in children are greater than in adults, because of the more perfect reparative process at that age.

5. The reconstruction of the canal is, *par excellence*, the operation, and, as shown by Bassini's statistics, has stood the test of time.

6. To obtain the best results a great deal depends upon the surgical technique, and the suture material employed.

7. Drainage should not be employed, if the surgeon is careful to observe the modern rules of cleanliness ; for if the wound is infected during the operation it must heal by granulation, and the drainage-tube is always an additional source of danger.

8. After primary and complete union of the whole wound no truss is necessary.

* * *

How Diphtheria is Propagated.—Dr. G. W. Goler, who is medical inspector to the Rochester Health Department, has been looking into the age, sex, school, occupation, milk supply and sanitary conditions of the dwellings of each one hundred patients with diphtheria, and he records in the *Buffalo Medical and Surgical Journal* the following causes, which in his opinion are

mainly responsible for the spread of the disease.

1. Gross defects in the plumbing and drainage (both house and subsoil) within and beneath the house.

2. Contact, either direct or indirect.

3. Contact through the milk supply.

As a result of these examinations he points out the remedies applicable under those conditions which have been shown to exist. These are:

1. Repair defective plumbing and secure adequate drainage in every home where defects are found to exist.

2. Guard all means of contact by sufficient and rigid quarantine, so that patients having had diphtheria shall be really well before they are allowed to mingle with others. Public drinking cups in schools and elsewhere to be abolished. A system of distributing lead pencils in public schools to be so arranged that each child shall have his own lead pencil.

3. Laws governing the construction and maintenance of those stables from which our milk supply is drawn.

4. The sterilization of all milk for children's use.

* * *

Power of the Interni.—Dr. Francis Valk, in an article in the New York *Medical Record* on dynamics or power of the internal recti, concludes from an examination of a hundred cases taken from his case book:

1. That in more than fifty per cent. of our asthenopic cases we find that the power of the externi exceeds that of the interni, in comparison with the usual proportions that should exist between these muscles; in other words, that insufficiency of the interni is much more frequent than is stated in the text-books. I found only three cases of insufficiency of the externi.

2. That I place very slight reliance on any test for insufficiency of the muscular power, when we reduce the visual impressions of one eye by any means. Consequently, I can only rely upon the old test of the actual power of each individual muscle to turn the visual axis of the eyeball, coincident with a ray of light, deviated by a prism, from a candle placed at twenty feet from the person examined. In forty-eight cases the vertical diplopia test did not agree, and was exactly opposite to that of the prism test in nineteen cases.

3. That in cases where the proportions of the muscles are as one to one, we may exercise the weak muscles for a reasonable time or as long as their power will increase, but I would state that I have found this exercise useful only in weakess of the interni. Or we may order prisms, combined with the glasses, with the base over the weak muscles. They may afford relief, and I have not found any of my cases develop a latent insufficiency from their use. In some cases these means afford, for a time, complete relief; but there may be a return of the muscular weakness; in other words, the improved power obtained by exercise or prisms is not constant.

4. That in all cases the error of refraction, either simple or with astigmatism, should be corrected by suitable glasses, and these should be worn for a month at least, before we attempt to correct any muscular insufficiency.

5. That, in diplopia, we should do a complete tenotomy, carefully performed, with as slight a laceration of the tissues as possible.

Lastly, that, in insufficiency well marked, after the results of several trials with the prisms are the same, we may then perform a partial tenotomy, as stated, with full confidence of a good result.

* * *

Caution After Tonsillotomy.—Dr. J. R. Briggs, the managing editor of the *Texas Health Journal*, in a letter to that journal from London, speaks of the care used with patients in the London Throat and Ear Hospital, and cites the following very strict directions to be observed by patients after removal of the tonsils, and cutting operations in the throat:

1. Go home in a closed vehicle, with mouth covered over with a scarf or other suitable wrapper. Remain quietly in the house for at least three days, using the voice as little as possible, and

avoid exposure to bad smells and draughts.

2. Avoid taking any crust, biscuit, or other hard food. The diet during this period should consist generally of what is known as *soups*, *sops and slops*. These should be taken neither too hot nor too cold, but at a tepid temperature known as milk warm.

3. Take the medicine prescribed, and wash the mouth out frequently with the gargle if such be ordered.

4. In case of bleeding, lie on the back, with arms extended over the head, and suck ice. If the bleeding is not by this means checked, come to the hospital or send for a doctor. With a view of preventing bleeding, excess in either work or play is prohibited and *stooping* should be *especially* avoided for five or six days.

* * *

The Treatment of Erysipelas.—The subject of the treatment of erysipelas naturally falls into the 1, dietetic, 2, constitutional and 3, local, says Dr. J. M. Anders in the *Therapeutic Gazette*. The following summary shows in a few words the proper treatment of this disease:

1. Proper attention to the diet is of paramount importance.

2. Stimulants are rarely necessary if the dietetic requirements are fully satisfied, but may be freely exhibited when indicated.

3. Of drugs, iron has been widely tested and found to be of great value, though it matters little which salt or preparation is employed.

4. Quinine, when administered with iron, reduces the temperature, supporting at the same time the vital functions.

5. The use of antiseptics *per os* is to be recommended.

6. Pilocarpus is in a small proportion of cases powerful to abort the affection. To reduce temperature merely, pilocarpus should be employed in intense pyrexia, particularly where the favorable morning remissions do not occur.

7. The question of the local treatment of erysipelas has not as yet been set at rest, but agents intended to exclude the air and such as possess a germicidal power, especially corrosive sublimate, are highly useful.

8. That the erysipelococcus of Fehleisen, which is found chiefly in the more superficial channels of the corium, may be attacked directly by the corrosive-sublimate solution when the latter is used after scarification, is quite probable.

9. In erysipelas migrans, the germicide should be injected beneath the skin, just beyond the edge of the part inflamed.

* * *

Deformities in Knee-Joint Disease.—Dr. A. M. Phelps contributes an article to the New York *Medical Record* on the etiology of the deformities occurring in knee-joint disease, in which he carefully reviews the old theories of deformity and concludes that typical deformities are produced by change of leverage and action of muscles due to:

1. A voluntary effort to relieve pressure and pain.

2. Involuntary spasm and contraction of muscles, which increases the deformity by advantage of leverage due to flexion.

3. Nervous irritation of groups of muscles due to localized lesion in or about the joint.

4. Exceptional deformities are produced by pathological destruction of bone or soft parts.

5. Outward rotation of the leg is produced by spasmodic contraction of the biceps after flexion has taken place. Flexion allows lateral and rotary motion at the joint.

* * *

Conservative Surgery of the Uterine Appendages.—Dr. J. M. Baldy (*New York Journal of Gynecology and Obstetrics*) considers the subject of the conservative surgery of the uterine appendages from the standpoint of the Fallopian tubes and the ovaries, and he thinks that from a careful study extending over some years, certain general propositions may not be out of place.

1. The vast majority of Fallopian tubes, whose canals have been closed by pelvic inflammations, are useless for all time.

2. There is no way in which we can with certainty distinguish cases in which the tube might again be rendered patulous, while infinite harm may be done by experimenting.

3. It is always well to save healthy ovarian tissue for the sake of the continuance of menstruation and ovulation where this can safely be accomplished.

4. Uncomplicated small hematomata and hydrops folliculi do not, as a rule, give rise to distressing symptoms.

5. It is extremely probable that in the vast majority of uncomplicated ovarian diseases upon which so-called conservative surgery has been used, the relief of symptoms has arisen not from the surgery, but from the enforced rest in bed, proper feeding, nursing, and removal from care and worry; the disease being general and not local.

6. Adhesions or prolapse do not necessarily necessitate removal of the uterine appendages.

* * *

Washing Out the Large Intestine With Oil.—According to Julio Robert (*Revista de Medicina y Cirugia Prácticas*, No. 419; *Rev. Internation. de Bibliograph. Médicale*, March 25, 1894), and quoted in the *Therapeutic Gazette*, Chercheffsky's method of washing out the large intestine with oil consists: 1. In introducing a Nélaton rubber sound through the anus and as far inward as the valve of Bauhin. 2. In injecting by means of this sound a Russian pound, or 407 grammes (13 ounces and 1 drachm) of olive oil at a temperature of 100.4°F. (38°C.). The patient is placed on the side and the sound introduced, the oil being poured in from a height of about twenty-four inches (sixty centimetres). The oil must in every case be injected in a slow manner. The method is of general application in cases of constipation. The fecal matters, expelled at about twelve hours after operation, are abundant and of a fetid odor. The evacuation can be hastened by the administration on the following day of a glassful of some saline purgative water. The intestinal washing should be made preferably four hours after the evening meal. The author details four cases treated by the above method, and suggests a similar treatment in all cases where symptoms of auto-intoxication, due to intestinal fermentation, are present.

* * *

Scarlatinal Otitis.—One of the gravest complications of scarlet fever is the suppurative discharge so often one of this sequelæ and so hard to cure. Dr. Frank B. Blaxall (*British Medical Journal*) has made a bacteriological examination of the discharge in these cases and it appears from his observations:

1. That the organism most potent in the etiology of the otitis media of scarlet fever is the streptococcus pyogenes.

2. That the less chance there is of contamination from the outer air through the external orifice the more the pyogenic cocci predominate over rod forms, but that prior to perforation of the membrane the occurrence of such organisms is not precluded, since they may ascend from the mouth and air passages.

3. That next to the streptococcus the most important organisms are the staphylococci albus and aureus.

4. That apparently the diplococcus pneumoniæ of Fraenkel or the bacillus pneumoniæ of Friedlaender do not play such an important part in the otitis media of scarlet fever as in that due to other causes.

* * *

Palliative Treatment of Uterine Cancer.—In cases where operation is impracticable as the malignant deposits cannot be removed entire, Boldt (*British Medical Journal*) recommends as the best form of treatment curetting and subsequent cauterization. Curetting and packing with pledgets saturated with chloride of zinc also proves beneficial. If rigid antiseptic precautions be taken piercing of the uterus by the curette may do no harm. The uterus is curetted, then the cavity is sponged with a mixture of commercial acetic acid (1 drachm), glycerine (3 drachms), and carbolic acid (20 grains). Lastly the cavity is packed with absorbent wool.

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BALTIMORE, AUGUST 11, 1894.

Typhoid Fever in the District of Columbia.

FOLLOWING hard upon the report of Dr. Osler on typhoid fever in Baltimore, comes a very thorough report of what ought to be done to reduce the mortality and morbidity from that disease in Washington. From the very full and carefully prepared report in the *National Medical Review*, it is seen that the average annual mortality from typhoid fever to 10,000 population in the District of Columbia was 6.2; in Philadelphia, 6.3; Chicago, 7.8; Boston, 4.1; Baltimore, 4.1; New York, 3.1; Paris, 6.1; Berlin, 2.0.

The causes of the disease are impure water, imperfect drainage of a polluted soil, infected milk and other things. Dr. Theobald Smith has shown that the Potomac water contains many bacteria, especially after heavy rains, and every stranger to that city who has seen the so-called "Potomac lemonade" wonders who used it before, so filthy looking is it.

Infection from a polluted soil may be either by: 1. The overflow and leakage from privies; 2. The leakage from defective drain pipes in the soil; and 3. The backing up of sewage in the sewers draining the lower parts of the city, and the flooding of basements and cellars.

What infected milk can do in spreading contagion is well known. There are still a large number of wells in use in the District, but many are closed each year as attention is called to their impure water. The following recommendations were made and the importance of carrying them out will be urged on the municipal government and on Congress:

1. The immediate abandonment of all wells within the city limits, exception only to be made in case of the absence of the Potomac supply, and where the wells, after repeated chemical and bacteriological examinations, have been found to be free from all possible sources of danger. But even these to be abandoned as rapidly as possible.

2. Purification of the sewerage system already existing, by replacing as rapidly as possible all damaged or defective drains.

3. The introduction of new sewers in advance of other improvements in parts of the city not now supplied with drainage, and the extension of the system as far outside of the city limits as the rapidly growing population demands, so as to prevent soil contamination.

4. The adoption of some system by which the lower sections of the city can be more completely drained, and the risks arising from the backing up of the tide water and sewage prevented.

5. The final and safe disposal of the sewage.

6. To make all existing privies, vaults or other receptacles of human excreta watertight, and by rigid inspection and penalties to prevent the dangers from leakage and overflow.

7. The early completion of the plans recommended by Colonel Elliot, in charge of the Washington aqueduct, and now in course of execution, which have in view the sedimentation of the Potomac water, and ultimately the completion of works for filtration, the only proper method of purification.

8. The suppression of all privies and the enforcing of the law to make sewer connections.

9. Careful inspection of all dairies in the District from which the milk supply is drawn, and the enactment of a law by which no milk shall be sold in the District without a permit

from the health office. The inspection should cover an examination at the dairies of all possible sources of infection, including the water supply.

10. The urging upon the members of the profession of a careful collation of all facts bearing upon the mode of infection in each case, and the advantage of reporting such facts to the Society, and the propagation of the doctrine that immediate disinfection of the stools is the first duty of the physician as guardian of the health of the community.

* * *

Ichthyol in Gynecology.

Ichthyol, or the sulpho-ichthyolate of ammonium, is obtained from a fossil's fishy deposit and is a thick, brown liquid with a smoky, and to some highly offensive, odor. It is soluble in water, in a mixture of alcohol and ether, in oils, glycerine and fats, and contains 15 per cent. of sulphur intimately combined. Its uses in gynecology have been briefly reviewed by Dr. Malcolm Storer in the *Boston Medical and Surgical Journal.* Its use in gynecology was first suggested by Freund in 1890, and it seems to have a wide variety of application. The theory is that by its reducing power it deprives the endothelium of the blood-vessels of oxygen, and so causes them to contract. It may be used in coated pills, taken two to eight times daily, each pill containing one and one-half minims; it may be used in ten per cent. strength in inunctions over the abdomen; in rectal suppositories containing three minims, or in ichthyol-glycerine tampons, five per cent. All the testimony was favorable until 1891, when Oberth, in Chrobak's clinic, showed that the salve and pills were worthless and the suppositories were only useful on account of the glycerine contained in them.

Storer's method was as follows: Every third day, after carefully drying the vagina, its vault was freely painted with ichthyol-glycerine, ten per cent., or with pure ichthyol, followed by a pad soaked in the solution, which in turn was guarded by a dry pad to protect the clothing. In addition to this, full hot douches were sometimes employed. Some cases where they were not used improved quite as rapidly as the others. In perhaps a dozen cases ichthyol pills were given. In nearly all cases the appetite improved. The use of the pure drug in the vagina seems to give better results than the suppository, but great care was taken and it was never used by the patient herself.

Dr. Storer has given an honest test to this drug and his reports are free from enthusiasm and his conservative stand taken will make his work of greater value. He concludes as follows:

(1) While ichthyol is by no means the gynecological panacea that some observers have claimed it to be, still it has sufficient approved value to deserve a very high place in our list of remedies.

(2) That while its chief action is to relieve pain it does possess certain resorbent qualities, which in some cases are relatively powerful.

(3) That its use is unattended with danger or discomfort.

(4) That the use of the pure drug is generally more satisfactory and reliable than that of solutions.

(5) That it has not yet been proven that it has any gynecological value other than as a local application.

* * *

Physicians in the District of Columbia who are pressing a bill for the regulation of the sale of milk little know what is in store for their health officer after such a bill is passed. In Baltimore such a law has been operative for several months and while unlike the land of Canaan there is no honey yet our placid and fearless health officer is daily causing the streets of Baltimore to flow with what certain persons call milk, but what the Commissioner claims is something else. The milkmen, tiring of having their wares so summarily disposed of, have united in some of the outlying districts and intend to test the law and engage an opposing chemist to establish just what good milk is. Some of the more irate dealers in chalk and water and swill products have even suggested that our health commissioner would look well in a dress of tar and feathers, but according to last reports that busy officer was getting his eight hours' sleep a night, untroubled save by heat and mosquitoes. The outcome of this resistance to the law will be looked for with interest and there is no doubt that some good will come from it.

* * *

It does not look as though Congress would have much time to consider the question of a national bureau of health.

MEDICAL ITEMS.

Dr. John W. Neff is again laid up with a broken leg.

A few cases of Asiatic cholera are said to have appeared in England.

Dr. Frank C. Bressler has been quite ill at his home with typhoid fever.

An International Congress for the Protection of Infant Life was recently held in Bordeaux.

Dr. George M. Gould, the editor of the Philadelphia *Medical News*, has been seriously ill in London.

The Canadian Medical Association will hold its annual meeting at St. John, N. B., August 22 and 23, 1894.

Bellevue Hospital in New York will shortly be enlarged and improved. It has needed this for a long time.

Dr. John S. Billings has been made Lieutenant-Colonel and Deputy Surgeon-General of the United States Army.

In France, physicians are not allowed to dispense any medicines at all. This law is evidently in favor of the pharmacists.

Dr. Lilias Hamilton has recently gone to Kabul to serve as physician to the harem of the Ameer of Afghanistan. She is carefully protected when she goes out.

Health, a new journal of hygiene, makes its appearance with a list of well-known contributors and a varied number of articles. It has no editorial page. It is issued quarterly.

Newark, New Jersey, is wrestling with a few cases of small-pox. It is strange that any city should have small-pox when vaccination is such an efficient means of protection.

The New York Academy of Medicine's superintendent of nurses has so arranged it that in response to telegrams from summer resorts or elsewhere a nurse will be promptly sent.

Recently the New York police made a raid on abortionists and arrested several of them. It is strange that such men are allowed to carry on their dangerous practices in the large cities.

Some man with an original idea has suggested that every soldier should have mapped out or tattooed on his body with India ink the course of all the principal arteries, so that in case of hemorrhage the proper places for pressure may be found.

An exchange notes that the Woman's Medcal College of Baltimore has very few women on its list of instructors and asks if this is an implied admission of weakness on the part of the gentler sex.

The plague in China is said not to be quite so virulent as it was at first, but nothing is being done in the country to prevent and now the additional horror of war may increase the already high mortality.

Another monthly which has entered the field of journalism is *The Nursing World*, which is published in Providence, R. I. Dr. J. Edmund Brown is the editor. It contains some good articles.

The American Association of Obstetricians and Gynecologists will hold its seventh annual meeting at Toronto, Ontario, September 19, 20 and 21, 1894. Dr. George H. Rohé will deliver the president's address. Among others who will read papers are Drs. William Warren Potter, of Buffalo, Thomas E. McArdle and I. S. Stone, of Washington, D. C.

Dr. J. F. Winn, so long and so well known as the editor of that very progressive journal called *Practice*, published in Richmond, has enlarged and improved his monthly and now calls it the *Richmond Journal of Practice*. He has ten collaborators, men well known in their specialties. The journal is printed on thick paper with clear type and it makes a very handsome appearance.

Mr. Carroll D. Wright has marked out the slums of Baltimore, much to the disgust of some very worthy people who happen to live within the lines laid down by him. They may console themselves, however, with the thought that Mr. Wright does not find cases of illness and death there in proportion to the crowded condition of that part of the city and the mortality is not as high as in other parts of Baltimore.

And now the fear is that the telephone mouthpiece may transmit disease from one person to another, and Germany has already introduced a special mouthpiece, the object of which is to avoid the spread of disease by the condensed moisture of the breath. A pad or a large number of discs of paper, with a hole in the middle, is inserted into the mouthpiece, and the upper disc is torn off after every conversation.

CURRENT EDITORIAL COMMENT.

SPECIFY YOUR REMEDIES.

Therapeutical Notes.

WHAT would be thought of the artisan who would leave the selection of his tools to chance or the preferences of another? Yet medical men, plying a craft infinitely more difficult and trying than that of any artisan, not infrequently permit others virtually to dictate what means they shall use in treating disease. Specify your remedies; do not leave their quality to chance or to another's choice.

TAKE A MEDICAL JOURNAL.

The Charlotte Medical Journal.

A MEDICAL journal to the young physician is of incalculable value. It brings him in direct contact with the rich treasures of experience gathered by men old in practice, and helps him over many a rough and ugly place, when the theoretical knowledge gained at college seemed of little use, and only the finger of experience could point the way to a solution of the problem. The best thing for a man when he enters upon the practice of medicine is to subscribe for a good journal.

STATUS OF MEDICAL EDUCATION.

The Journal of the American Medical Association.

A RAPID evolution in medical education is apparent in this country. Not content with the extension of requirements for the degree of M. D. from two to three courses of lectures, there is most convincing evidence in the events of the last few weeks that point to the immediate adoption of the four course requirement by every reputable medical college in the country. The action of the College Association in adopting the four years' course with attendance upon four courses of lectures goes into operation in 1895. All the colleges in Chicago, Harvard University, University of Pennsylvania, College of Physicians and Surgeons, New York, Jefferson Medical College, University of Michigan, University of Minnesota, and many others have already adopted the four-term requirement. The indications point to definite action in the adoption of the four-year course at once by all the colleges in Ohio, Missouri, Iowa, and by a limited number of the Southern schools. The extension of the courses of medical instruction will reduce the number of students somewhat, but not enough to affect the income of the colleges. Experience has shown that in the last few years colleges extending their courses have had increased attendance and largely increased incomes.

DOCTORS' AND LAWYERS' FEES.

Pacific Medical Journal.

THE daily papers at the present time are congratulating ex-President Harrison upon receiving a fee of $25,000 for four hours' work in court; had a medical man of equal or more ability than Mr. Harrison charged a many-times millionaire $5000 for a month's constant attention, the whole press would be charging him with robbery—a man to be avoided when you are sick, etc. Another case in point. Judge Levy, of this city, has just allowed a firm of attorneys a fee of $80,000 for looking after the routine business of an estate for a few months, and yet this very same judge refused to allow a fee of $30,000 which a medical man had presented for many months' attendance on a millionaire and his family. The actual work was probably 100 times more than that performed by the attorney who received $80,000; while the responsibility was probably 500 times more, yet his Honor, Judge Levy, saw fit to cut the doctor's fee down to $10,000. And why?

MEDICAL EXPERT TESTIMONY.

The Railway Surgeon.

A MEDICAL man in the witness box should remember that he is there not alone in the interest of justice in the particular case at issue, but that he owes it to himself to honestly and faithfully represent his profession and to sustain his own reputation as a scientific physician and a man of honor. It is not only the privilege but the duty of every medical witness to set himself right in the minds of judge and jury before leaving the stand, if he feels that his testimony has not been understood or that the cross-examination has placed him in a false light. We have often seen the truth of this assertion exemplified and have been pained to see some of our friends, bright, capable men, too, hasten to leave the witness stand stinging from the sharp thrusts of an impertinent attorney and perhaps the smiles of a jury, when a few quiet words of explanation would have cleared the air of all doubt as to the stand of the doctor on the side of science and justice and enabled him to leave the room strong in the confidence of everyone present.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

The safest mode of remittance is by bank check or postal money order, drawn to the order of the *Maryland Medical Journal*; or by Registered letter. The receipt of all money is immediately acknowledged.

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TO PRACTITIONERS OF MEDICINE.

The Medical Law as repealed and re-enacted, with additions and amendments, by the Maryland State Legislature, has been printed at this office in neat and convenient form for physicians. Copies may be obtained at the Journal Office or will be forwarded by mail on receipt of 15 cts. in stamps or coin.

NOTES.

THE oxalate of iron is an excellent remedy in chlorosis.

*

STRYCHNINE nitrate is the latest remedy for alcoholism.

*

COBALT nitrate has been proposed as an antidote in hydrocyanic acid poisoning.

*

PHENACETIN and salol form an excellent combination for the treatment of cystitis and urethritis.

*

INTESTINAL flatulence with indigestion will often yield to repeated doses of the spirit of chloroform.

*

CYSTITIS in the female may be relieved by washing out the bladder with a weak solution of creolin.

*

VIOLENT hemorrhage from the extraction of a tooth may be stopped by plugging the socket with cotton steeped with oil of turpentine.

*

SENECIO vulgaris, one to two drachms of the tincture, or twenty drops of the fluid extract, three or four times a day, is said to be an excellent emmenagogue.

*

A VERY effective but disagreeable way of treating fibrinous rhinitis is by thorough irrigation of the nasal cavity with warm water and then giving copious insufflations of iodoform.

READING NOTICES.

Cholera Infantum.—

℞.—Bismuth, Subnit.	. .	℥ss
Tr. Opii.	. . . .	gtt. xx
Syr. Ipecac Syr. Rhei Arom.	aa. .	℥ij
Listerine	. . . .	℥ss
Mist. Cretæ	. . . .	℥ j *M.*

Sig. Teaspoonful as often as necessary, but not more frequently than every three or four hours. This for children about ten or twelve months old.

*

Bromidia.—T. H. J. Pryce, M. D., etc., No. 4 Lorne Villas, Clevedon, Somerset, England, May 23, 1891, writes: I take pleasure in giving the following notes on Bromidia. A patient, age 28, suffering with pneumonia and typhoid blood poisoning (the latter was contracted when in the convalescent stage), complained of insomnia, and I put him on Bromidia. Even when in good health he had suffered more or less from insomnia, but after having taken Bromidia he slept without difficulty and very naturally, and no headache or constipation followed its use, as was the case when other narcotics were administered. I was very pleased with the results, and prescribe Bromidia often now.

*

Security against Imposition.—This heading is suggested by and is particularly applicable to the new advertisement of the Antikamnia Chemical Company, which appears in this issue. Antikamnia, while not suffering anything like other standard preparations from substitution, has still found it in some few instances. To the end, therefore, that there may not be even the breath of suspicion against Antikamnia, as well as to give every doctor the fullest confidence, the company has gone to the expense of withdrawing all the old stock from the market and replacing it with new. In the new form the drug is identically the same chemically and medicinally as it has always been, but every tablet bears imprinted upon it a monogram. (See advertisement.) Every package of Powder or Tablets is so wrapped and sealed and resealed as to render counterfeiting impossible. The entire profession should insist upon the safeguards provided, and there can be no question but that this action will be regarded with great favor by them. The latest edition "Antikamnia and Codeine" tablets, can be obtained direct, or from your druggist. Each tablet contains 4¾ gr. Antikamnia and ¼ gr. Codeine.

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ORIGINAL ARTICLES.

TROCHES.

By William T. Cathell, M. D.,
Baltimore.

As a large number of patients suffering with throat affections have more or less difficulty in swallowing, it is of considerable importance, in treating them, that a suitable method of administering the proper remedies be at the command of the practitioner. Such a need is more or less filled by the various medicated troches that are made by manufacturing chemists, and it has been a matter of some surprise to me that their use is so limited among American physicians, while in Great Britain and on the Continent they are largely prescribed and with the most satisfactory results.

Their great advantage consists in our being able by their use to keep the selected drugs continuously in contact with the irritated or diseased mucous membranes of the fauces and throat, by which we obtain more prolonged topical action than would otherwise be possible with even a greater quantity of the drug.

In reliability they are necessarily superior to all gargles, which fall short of what is required of them. Especially is this true when we have a lesion posterior to the faucial pillars, owing to the fact that the ingredients are gradually dissolved in the saliva and thus brought in immediate and prolonged contact with the affected parts, whereas in a gargle the drug is greatly diluted and never reaches beyond the palato-pharyngeal fold. It can not therefore be otherwise than logical to conclude that better results will be obtained from slowly-dissolving troches than the non-permanent contact of gargles; for gargling, to say the least, is disagreeable to a great many patients and to some indeed impossible.

In laryngeal disease the efficacy of troches may be at times doubtful, still they have a long-standing reputation for usefulness in all voice affections, due probably to their exciting a reflex influence upon the larynx through the path of the laryngeal plexus of nerves, aside from their direct local action.

Their usefulness has now been too thoroughly demonstrated to require any extended explanation as to their efficacy. A troche should be dissolved upon the middle of the tongue, not too near the tip, so as to fully impregnate the saliva and bathe the membranes before being swallowed. A valuable property which the ideal troche possesses is the persistence with which it adheres to the mucous surface, and it is on this account that some are more effectual locally than others.

I have found them of service in various acute inflammatory diseases of the throat; and also in most chronic affections of that organ, combining absolute accuracy of dose, convenience in administration, speedy disintegration, and consequently rapid absorption, thereby obtaining the most effective results. And with me they have met the de-

mands of a large class of out-door patients.

Of course a thousand and one combinations could be made, but for every-day cases I have devised the following varieties and find them to admirably cover the ground in ordinary practice.

Muco-Stimulant	Apomorphia, gr. $\frac{1}{20}$ Solid Ext. Eucalyptus, gr. $\frac{1}{8}$
Muco-Sedative	Ext. Pulsatilla, gr. $\frac{1}{12}$ Ergotin, gr. $\frac{1}{16}$ Codeina Sulph. gr. $\frac{1}{24}$ Ext. Bellad., gr. $\frac{1}{48}$
Muco-Tonic	Kalii Chlor., gr. j Cubeb Oleo. Resin, ää. gr. $\frac{1}{3}$ Pulv. Ipecac, Catechu, gr. $\frac{1}{3}$ Balsam Tolu, gr. $\frac{2}{3}$ Capsici, gr. $\frac{1}{50}$

Their respective terminations of name serve to indicate their therapeutic uses, saving the necessity of memorizing endless varieties of formulæ and indications.

I may remark here that the manufacturer has combined in each formula an unobjectionable excipient selected for its elegance and palatability.

When either of these is used in the treatment of oral, faucial or pharyngeal affections chiefly for its local effect, it not unfrequently plays an exceedingly useful role, either alone or as an adjuvant to other treatment.

Confectioner's troches do not answer our purpose, being defective in the dosage, and so easily breaking and chipping as to make them unreliable. They fall to pieces too quickly in the mouth, and are affected too easily by the weather, and result in giving dissatisfaction to the patient and injuring the prescriber's reputation.

Recognizing the usefulness of these combinations in daily practice and the advisability of having them properly and pharmaceutically prepared, I gave the above formula to a well-known manufacturing pharmacist of Baltimore, who has devoted many years of his professional attention to the manufacture of troches, knowing that, with his experience in this line and his requisite facilities for their manufacture, they would be made as perfect as present art will allow. As now made by him, they are especially adapted and intended for prescription use, being dispensed in tube vials of 36 troches each, in which form they are convenient for carrying in the pocket and are thoroughly protected from the influence of the atmosphere.

Muco-Stimulant.—The action of these is astringent, stimulant and antiseptic and most marked upon the mucous surface, preventing the formation of a thick tenacious mucus. I have, moreover, found them of special advantage in obstinate coughs by promoting marked expectoration and mollifying many bronchial and laryngeal troubles. Again, while they possess valuable stimulating properties they are free from the extremely bitter taste that characterizes many of the other troches; in this respect they contrast strongly with catechu, kino, etc., which greatly favors their administration to children and fastidious patients.

Muco-Sedative.—This troche sheathes and produces a soothing, calmative effect, lessening the the tendency to cough and relieving throat soreness. I have found them of marked benefit where the throat and tonsils are acutely inflamed and much swollen. They quickly mitigate irritation, liquefy tenacious mucus and lessen expectoration and do not constipate. If a patient's cough is severe and irritating two or three may be allowed in succession. I have used them in the early stages of mercurial salivation with wonderful benefit.

Muco-Tonic.—In regard to this troche I may say, with emphasis, that I know of no other combination that has so many points of merit, and is so effective in its action.

I have recently added to the original formula a small quantity of capsicum and find that the slight glow it produces increases their usefulness. And now after an extended use of this combination I find its value both increased and confirmed. They are admirably adapted for allaying slight irritation of the throat and giving tone and flexibility to the vocal organs.

In many cases, and especially those of a chronic character, the best effect can only be secured by their prolonged and systematic administration.

Probably the most frequent and troublesome form of throat affection that is met with by the general practitioner is that condition where the throat seems a little weak, with insufficient tone to voice, due ofttimes from over-exertion in speaking or singing, and confined mostly to those who depend largely for a livelihood upon the voice, so that perfect resonance and timbre are all the more imperative, and in such cases as these I can with confidence aver that this troche is perfect, which is one of its chief sources of reputation. Further, for dry cough, hacking throat with slight expectoration or weak voice they can be relied upon and will be found of service. In relieving many cases of fetid breath from disordered secretion they have proved efficient correctives.

Finally, if this trio of troches answers in other hands as well as they have in mine therapeutically, and assist the legitimate physician in supplanting the various quack lozenges now in indiscriminate use among the laity, my object will be fulfilled.

CLINICAL LECTURES.

OVARIAN TUMOR; OVARIOTOMY.

Delivered at the Jefferson Hospital, January 2, 1894.

By E. E. Montgomery, M. D.,

Professor of Clinical Gynecology, Jefferson Medical College; Gynecologist to Jefferson and St. Joseph's Hospitals; Obstetrician to Philadelphia Hospital; President Alumni Association, Jefferson Medical College.

Gentlemen: I bring before you a patient to-day with the following history: She is 35 years of age, married, has had six children, four of which were instrumental; her last labor at term occurred one year ago. She suffered from a miscarriage of a three months' child six weeks ago, after which she remained in bed but seven days, and has continued to have a discharge of blood through the vagina since. The discharge is increased by exertion. She has experienced no pain excepting the sensation of weight in the pelvis and in the region of the perineum. The appetite is poor, the stomach irritable, and the bowels constipated. She has worn a pessary, which from her description was evidently one with external support. Inquiring into her family history, we find her father died of epilepsy, her mother is living, and she has brothers and sisters living, who are in good health. She was healthy as a child; puberty occurred at 13, was regular and painless. We find she has been suffering from a bloody discharge following the abortion, some seven weeks since. This of itself would indicate the possibility of some diseased condition of the uterus. Hemorrhage from the uterus, however, is not necessarily a positive indication of disease confined to that organ. In other words, while hemorrhage may take place from the uterus, it may be due to diseased conditions outside of it. A patient complaining of hemorrhage from the genital tract should be subjected to a careful examination, as it may arise from a variety of causes. Thus, it may be due to a retention of products following parturition or an abortion; to diseases of the endometrium, producing what is known as hemorrhagic endometritis. Malignant disease of the cervix or its canal, or of the body of the uterus, may be the cause of the hemorrhage, even in women as young as the patient before us. Fibroid growths projecting into the cavity of the uterus are a frequent cause of hemorrhage. Hemorrhage may also result from interference with the pelvic circulation, from the presence of exudation in the broad ligament, obstructing the uterine and ovarian veins. This obstruction may be due not only to an inflammatory exudation but to the pressure arising from a preg-

nant growth in one or the other broad ligament. Cystic disease in one or both ovaries is not infrequently a cause of hemorrhage. Then, too, it should be remembered that uterine hemorrhage may result from the presence of zymotic disease, from disease of the heart, the kidneys, or of the liver. From this enumeration of the causes of genital hemorrhage, you can appreciate the importance of the careful study of each individual patient to determine the particular cause. You should not be content in any case with simple treatment of the symptom, but rather insist upon a thorough and careful examination, as upon the accomplishment of it may depend the chances of your patient for future comfort, health, or even life. Consequently we make careful examination of this patient; we have already thoroughly examined the secretions, and found no indications of disease of the heart, or liver, and that the kidneys are healthy. Making examination of the uterus we find it somewhat larger than normal, indicating that the processes of involution had not been completed. With the history of a patient having had an abortion so recently, and followed by continuous hemorrhage, and the examination disclosing a large uterus, we would be justified in suspecting that there was some retention of the products of conception as a cause of the symptom, hence we consider it necessary in this case to carefully dilate the uterus and curette its cavity in order to relieve her. Our examination has disclosed that there is a diseased condition in addition to that of the uterus, as a mass can be distinguished behind the uterus in Douglas' pouch, which is quite movable, about the size of a hen's egg, and a little longer than it is round. It is slightly elastic, not presenting a hard, dense feel. Its situation, its shape, and its distance from the uterus, lead us to suspect the existence of a small ovarian cyst. That it is not an enlargement of the Fallopian tube is evident from the fact that it is freely movable, and presents no indication of inflammatory adhesions. It is a rounded mass, presenting no difference in the enlargement from one end to the other, and can be separated readily from the uterus. The first step, then, in the treatment of this patient, will be the dilatation and curetting of the uterus. In doing this we are particularly careful to observe as thorough aseptic precautions as we would if we were opening the abdomen. The external parts of the patient have been thoroughly shaven and washed. The vagina has been irrigated with sublimate solution two or three times daily. As a preliminary to the operation we thoroughly scrub the vagina by introducing two fingers wrapped with gauze within it, and pouring into it a solution of tincture of green soap and creolin. After careful washing of the vagina with this, which removes all the debris and desquamated epithelium that was lodged between the interstices or folds of the vagina, we irrigate it with sterilized hot water. The uterus is seized by the anterior lip with a pair of three-pronged volsella forceps and the organ dilated by the introduction within it of graduated bougies, using them up to number 43. The cervix presents a number of fissures, showing previous laceration. After the dilatation of the uterus, the cavity is thoroughly curetted by means of the Duke curette, which has an opening through the handle through which, by the use of a fountain syringe, fluid can be carried into the uterus, playing directly upon the surface in which the curetting is practiced. In this way the material is washed away as rapidly as it is scraped off. For this purpose of irrigation we use a one per cent. solution of creolin. After curetting, the cavity of the uterus is packed with iodoform gauze, carrying the gauze to the fundus of the uterus and packing it quite firmly. Another tampon of gauze is placed in the vagina and a gauze pad over the vulva externally. The parts will be kept clean and the gauze pad changed as often as it becomes soiled. Now we propose to open the abdomen for the removal of the mass within the pelvis. The abdominal wall is relaxed through the previous distension during gestation. Opening the abdomen, passing two fingers behind the uterus, the left ovary and tube are raised up, the ovary presenting a tumor

about the size of a hen's egg. The left tube is unenlarged and apparently uninflamed. The mass is raised up, the pedicle ligated with silk, and the tumor removed. The other ovary is then examined and found to present a cyst nearly as large as the ovary upon its anterior surface. As the remaining portion of the ovary was healthy this cyst was opened, the sac peeled out, the edges trimmed and the ovary sewed up with kangaroo tendon. The abdominal wound was then closed by two rows of tendon suture. Our conservative operation upon the right ovary would prevent this woman from becoming subsequently sterile, as the healthy portion of the ovary will be sufficient to keep up procreation. After the wound is thoroughly cleansed and dried, a piece of gauze is placed over it and the edges of this sealed down by the application of collodion. The surface of the gauze is dusted with iodoform and boracic acid, and a thick layer of sterilized cotton applied. This is held in place by tapes and plaster, and a bandage. The after-treatment of the patient will consist in keeping her perfectly quiet, giving nothing by the mouth for twenty-four hours, and having a rectal enema of half a pint of hot solution of salt to which thirty drops of tincture nux vomica is added. This injection will be given every three or four hours. The influence of the salt solution is, through its absorption to increase the watery portion of the blood, and acts practically as a salt transfusion. The addition of the tincture of nux vomica stimulates the nervous centres, increases the strength of the heart's action, promotes peristaltic movement of the intestines and decreases the probability of retention of gas and the development of tympanites. To-morrow morning, should she have recovered from the nausea and vomiting, we will give her a cup of tea; follow that by from a teaspoonful to a tablespoonful of the liquid peptonoids every two or three hours. The second day we will give her a poached egg, toast, cup of tea or coffee, and gradually resume ordinary diet. We will not give her any milk for the first week, for the reason that it has a large amount of casein or curd and increases the quantity of flatus. If the patient's temperature should become elevated we will at once administer salines. In fact, it is not bad treatment to begin the use of salines within the first forty-eight hours, making sure thus to cause evacuation of the bowels, the passage of flatus and the prevention of unfortunate adhesions and the danger of obstruction. Should the stomach be irritable, calomel in good-sized doses may be given. We will avoid absolutely the use of any anodyne —opium, morphine, etc.—as they lock up the secretions and thus decrease the power of elimination. In this, as in all circumstances, we are, however, obliged to be governed by the particular conditions. Thus, some patients bear pain more poorly than others. If a patient is excessively restless, the administration of an opiate or hypodermic injection of morphine may be less injurious than to permit her to go without it.

The administration of such remedies, however, should be looked upon unfavorably. Salines act freely upon the bowels. It is a question, however, whether our future investigations may not disclose the fact that increasing the salts in the blood, they promote the germicidal action of that fluid. Recent investigations of Vaughan have shown that the blood has a decided germicidal power and that this power is accelerated by the addition to it of some of the salts. The salines, in developing peritonitis, or in congestion of the peritoneum or in abdominal pain resulting from this engorged state, are more beneficial than opiates, because while they increase the peristaltic action they cause a free watery discharge which unloads the congested vessels and consequently decreases the pain. We do not always find patients do well. For some reason, possibly the presence of pathological germs or their escape through the walls of the intestines, we may have indications of sepsis. The abdomen becomes distended, producing what is known as tympanites. With the distension of the abdomen there is pressure against the diaphragm interfering with the respiration and heart's action, the pulse be-

comes rapid and the general comfort of the patient greatly decreased. In such cases the administration of an anodyne, as morphine, aggravates the distress. She suffers increased distress from the reason that its administration decreases the peristaltic action. It is better to give strychnine, $\frac{1}{30}$ to $\frac{1}{20}$ grain hypodermically every two or three hours, until it has had some effect. At the same time salines may be administered and stimulate peristaltic action. A good free enema may be given. In some cases the treatment will be begun by the administration of an enema containing an ounce each of sulphate of magnesia, glycerine and water. If this is not effective the patient may be given a large injection of soap and hot water to which an ounce of turpentine beaten up with the yolk of two eggs is added ; or asafetida, a couple ounces of the tincture, or oxgall, may be found beneficial. A couple of quarts of hot soap-suds in which half an ounce or an ounce of ox gall is dissolved carried high up in the bowel frequently results in stimulation of the peristaltic action, evacuation of the bowel, and discharge of large quantities of gas. The methods here suggested are usually sufficient to accomplish relief of the patient. Where she is not relieved, however, the bowels continue distended, she suffers from pressure against the diaphragm, interference with the heart's action, very marked relief may be obtained by the introduction of the stomach tube and washing out the stomach. The upper part of the intestinal track is thus emptied, a large amount of offensive material is removed and the patient may be more comfortable. I have seen patients in whom I am confident the use of the stomach tube meant the difference between life and death.

Causes of Sterility.—It often happens that the sterile woman longs for children, while the woman who conceives and bears easily is also dissatisfied with her condition. Of the former class there are many in whom no cause of this sterility can be found, and Dr. Thomas A. Ashby, in the *American Journal of Obstetrics*, who in a paper before the American Gynecological Society, takes up the subject of the influence of minor forms of ovarian and tubal disease in the causation of sterility, draws the following conclusions from the study of the subject and from his experience with several cases:

First. The adjustment of the tube and ovary during ovulation is effected in the human female by the most delicate mechanical arrangement and may be defeated by trivial mechanical interferences.

Second. In animals that habitually have multiple pregnancies a more perfect mechanical provision is made for the reception of the ovum by the tube. The number of ova impregnated seem to bear a close relation to the perfection of the arrangement which is provided for their passage into the tube. Thus in the bird will be found the most perfect type of mechanical adjustment, in woman the most intricate and difficult.

Third. The adjustment of the pavilion of the tube to the ovary may be set aside by the most trivial vices of structure and disease, resulting in absolute or relative sterility.

Fourth. Sterility is due to minor diseases of tubes and ovaries to a greater extent than has been recognized. In an investigation of the etiology of this condition this fact should be considered in connection with an investigation of other causative influences.

Fifth. The highest aim of surgery is to restore and not to destroy function. In the treatment of minor forms of ovarian and tubal disease this fact should be borne in mind. Organs should not be sacrificed to the rule of expediency, but should be preserved in deference to a law of genuine conservatism.

* * *

Ague is most fatal at Rome, there being 460 deaths in every 10,000 annually in that city from this cause. The ratio in the United States is 240 to 10,000, and in London only two.

TUBERCULOSIS AND SYPHILIS OF THE LUNG.

DELIVERED AT THE CHARITÉ HOSPITAL

By Professor Potain,
Paris.

Gentlemen: A man has just been admitted to the male ward who has both tuberculosis and syphilis. Let us consider for a moment what influence one of these troubles will have on the other. His father died of tuberculosis and one sister died from pulmonary consumption and he has one brother who is twenty-five years old who is well.

The patient, who is twenty-nine years old, has never had rheumatism nor malaria; he does not take cold easily and has been in health up to September, 1892, when he contracted a chancre, followed by a variety of eruptions. Soon after this he commenced to cough and had increased expectoration, but has never had hemoptysis. For about four months he has had slight daily fevers and in the same time he has fallen off quite rapidly. Indeed, when we examine him we are at once struck with his extreme emaciation. He has no fever at the present moment and the evening temperature does not exceed 98° F.; his pulse is 104, which is too rapid.

On examining the chest it is seen that the dullness is very accentuated in the right supra- and infra-spinatous fossæ; indeed, it is absolutely dull, just as if one were percussing the femur. From the absolute dullness in this region we pass without any gradations to clear, healthy lung. As the vibrations are more markedly flat in the infra-spinatous fossa than in the corresponding point of the opposite side we may dismiss any idea of an effusion. On auscultation in this region fine râles of medium intensity and rather marked are heard. In front the fine crackling moist râles just under the clavicle are easily made out. All over the right side the vesicular murmur seems to be immediately under the ear, which would show that there is a certain thickness of healthy lung over the diseased part.

The patient has little appetite, no diarrhea, his liver is large and his spleen is in every direction much enlarged, being over eight inches in its greatest diameter. The patient seems to show for the most part all the signs of phthisis. The apex of his right lung is changed to a dense mass, while the rest of that organ is normal. Examination of the sputum shows a large number of characteristic tubercle bacilli.

Now, this man is syphilitic and the question is, will this syphilis grow worse; or, is it in a state of activity and if so, is not the lung itself affected with it? Pulmonary syphilis has been known for a long time. Gummatous deposits in the lungs are analogous to those in other organs. They are very much like tubercles and often attain a size many times as large as a goose egg. The connective tissue is much more abundant in the gummata than in the tubercles, and more on the surface and form a sort of membranous envelop. The gumma generally finds its seat more in the central part of the lung than on the outside. As it is, the presence of tubercle bacilli renders a diagnosis easy and rapid. Syphilis often causes a pulmonary hardening or sclerosis with thickening of the connective tissue; this sclerosis frequently occurs with pulmonary syphilis, has no especial significance and usually occupies the middle part of the organ. It is usually present with gummata. Virchow has described a special form which he calls white pneumonia. There is atelectasis and collapse of the vesicular tissue and penetration into the vesicular cavity by epithelial desquamation. This form of lesion is usually situated in the lower part of the lungs and may be present in hereditary infantile syphilis.

Pulmonary syphilis has certain special signs which allow it to be distinguished clinically from tuberculosis. The dullness has a sharp clear line of demarcation and often the apex is intact. Meanwhile it is well to bear in mind that there are more syphilitic lesions at the apex than in the middle part of the lung, and a situation at the middle part of the lung has only a diagnostic value.

The syphilitic lesion has less hyperemia about it than the tuberculous lesion.

The local heat which often accompanies the evolution of pulmonary phthisis is often wanting in syphilis of that organ. With equal invasion of each lesion dyspnea is more marked in syphilis than in phthisis, which goes to show without doubt the frequent existence of an extended sclerosis. In other respects the tubercles which have undergone a pulmonary sclerosis also cause a very marked dyspnea.

Blood-spitting is more rare and less abundant in syphilitics who have a general but not very high fever; they also fail to have the cachectic appearance so common with the tuberculous, and the general health seems to be fairly good in spite of the extensive local lesions. Syphilitic lesions of the lungs show themselves at the end of the second stage and they are often very late in appearing. They may also be the only manifestation of a hereditary syphilis and it is easy to understand that under these circumstances the diagnosis is not very difficult. Syphilis may attack other parts of the respiratory tract than the lung, and I am sure that laryngeal syphilis which may be plainly seen is well known. But there is also syphilitic bronchitis and bronchial gummata may appear, followed by ulcerations, with genuine gummatous coverings. Syphilitic bronchitis generally begins early and is obstinate and resists the usual drugs, but yields rapidly to specific treatment.

I must now tell you of a case which, in connection with syphilitic lesions of the lungs, has also tuberculosis with bacilli in the lungs. This connection may be often seen and in the great majority of cases it is the syphilis which opens the scene, and the tuberculosis develops much later. At the autopsy there are found gummata and sclerosis of the lung and more tuberculous growths or disseminated granulations. It is remarkable to see how the tubercles grow everywhere at the border of the syphilitic lesions and everywhere at the places attacked by what Virchow calls white pneumonia. Syphilis seems to encourage tuberculosis and furnishes for it a good culture medium.

This patient that I show you to-day has been syphilitic for thirteen months. We may presume that he has had a syphilitic bronchitis and that this bronchitis has permitted the invasion of the tubercle bacilli. You may remember that I said that he began to cough a little while after he contracted the chancre, and that his bronchitis persisted. Is then the syphilis in this case in the process of evolution, or is it in an active state? I think we may admit the latter, for, on the one part, the limitation so sharp of the dullness at the apex of the lung is a sure sign of a syphilitic lesion of that organ, and on the other hand, the spleen is enlarged without his having had malaria. All acute diseases may have as a sign a hypertrophy of the spleen.

Certain authors have collected figures to show that fifty-five out of fifty-eight times the spleen is markedly enlarged in syphilis or in tuberculosis, and tuberculous granulations or gummata may be found there. According to a German statistician, in infants who have died of a non-infectious disease, the weight of the spleen is $\frac{3}{1000}$ of that of the body, while those who have died of an infectious disease, $\frac{4}{1000}$ had enlarged spleens, and, indeed, in the case of syphilis, $\frac{7.50}{1000}$.

All this may allow us to say that syphilis is still active in this man. Also it is very proper in this case to exhibit the antisyphilitic remedies which have so often such excellent and such rapid results. It is thus in the case of rapid cure one may say with justice the treatment has shown the nature of the disease. Probably the best thing in this case is to resort to the mixed treatment.

We may give mercurial inunctions in order to spare the digestive system and to be able to give the iodide of potassium in sufficiently large doses and long enough. Mercury will alone be enough perhaps, since according to the statement of an Italian author, a man who was considered tuberculous, who had taken by mistake the blue ointment, which

had been prescribed for his pediculi, recovered from his phthisis.

Still in other cases the iodide of potassium given alone has seemed to have a rapid action. In spite of that, in most syphilitics with pulmonary lesions, the association of the two forms of treatment seems necessary, and it is better to order both of them when the digestive tract is in good condition and the absence of a cachexy too far advanced does not contra-indicate either of them.

MEDICAL PROGRESS.

DISTRACTION IN HIP DISEASE.—Certain diseased conditions of the hip joint tend to recovery if the condyle of the femur can be kept for a certain length of time from coming in contact with the acetabulum. This Drs. Edward H. Bradford and Robert W. Lovett discuss in the *New York Medical Jonrnal* under the head of distraction. From a number of cases kept under observation for many years these operators have certainly obtained good results. They say that it can not be supposed that the best results can be obtained by the application of inefficient traction. A sufficient amount of traction, constantly applied during the stage of muscular spasm, is needed. It is, of course, not the only therapeutic measure which is required; fixation and protection are also needed at the various stages. If traction is not applied properly, or is applied at the wrong time, or is insufficient in extent, it is no more efficient than a drug injudiciously or wrongly used or administered at the wrong time. Judgment is required in the use of this measure as of any other, and a great deal of care and attention to detail is necessary to insure the constant application of from eight to ten or fifteen pounds' traction uninterruptedly for two or three or six months, not only on the part of the surgeon, but on the part of the nurses and assistants. It is owing to the defect in this respect that in many cases treatment by traction is ineffectual, and the results obtained are not as satisfactory as desired. This leads to an unjust condemnation of the methods of treatment by traction by those who have tried this method, and, having met with unsuccessful results, have blamed not their own method of application, but the method in general, which is as irrational as if any one who administered a drug in an insufficient dose should lay the failure to the drug, when it is properly due to its faulty administration.

The thorough use of traction—*i. e.*, to the point of distraction—requires on the part of the surgeon not only a familiarity with the mechanical details of apparatus and the proper application, adaptation, and fitting of appliances suitable in each case, but the ability to arrange for such co-operation and assistance on the part of nurses or attendants as shall insure the continuance of the necessary amount of traction at all times. If this is not done the results are not complete, just as the lack of asepsis in an assistant or nurse may vitiate results in an operation, no matter how careful the surgeon may be personally. In the same way if, through the neglect of a nurse, a hip which needs continued traction of ten to fifteen pounds for protection against blows from muscular spasm is left during an acute stage for a time with a traction of two pounds, the joint may be seriously damaged.

Unusual care is required both in the management of cases and in the direction of hospital services. This care, however, is not greater than is possible if sufficient attention is given to the subject and the surgical indication borne in mind.

In conclusion, it is claimed that at a certain stage in hip disease traction force is desirable; that the amount of traction should be in proportion to the amount of muscular spasm, and continued as long as the spasm persists. It is also clear and demonstrable that an efficient traction force distracts, and it is manifest that distraction, or the separation of one inflamed bone from an adjacent inflamed bony surface, is desirable; that in this way every chance is given to promote cure and cicatrization of the previously inflamed bone. If an indication for surgical treatment is ever clearly written in pathological specimens, cer-

tainly that of distraction should never be overlooked. It should always be remembered that in treating hip disease at a certain stage the object should not be simply rest, or fixation, or protection from jar, but actual distraction, and that traction short of this is inefficient.

* * *

Infantile Scurvy.—Dr. Henry Fruitnight contributes to the *Archives of Pediatrics* a very lengthy article on the differential diagnosis of infantile scurvy, in which he relates several cases and then gives from them the prominent symptoms of the disease.

The disease seems to have a predilection for the lower extremity, usually in the region of the knee and ankle joints, which become preternaturally immobile, simulating in a manner a pseudo-paralysis of the affected limb. This is accompanied by exqusite tenderness when touched and also by a considerable amount of tumefaction. This swelling is usually fusiform or longitudinal; this cylindrical swelling of the lower ends of the femur and tibia are the most characteristic bone symptoms; sometimes the radius may be similarly affected. The skin over the swellings is always tense, shiny, pale, and without local heat. Nor does the swelling pit on pressure as is the case in edema or superficial tumefaction. This is the character of the swelling because it is produced by the deep thickening of the shaft of the bone. In this condition of the bone there is great liability to fracture near the epiphysis. The gums may be affected, ranging from swelling and sponginess to slight ecchymoses. Fever may be present or absent. In cases which have persisted for a long period profound anemia will supervene. Hemorrhages under the skin and collections of blood in the tissues are met with in cases which have remained untreated for a considerable time after the first irruption of the disease forming spots of ecchymoses or petechiæ. The skin covering these extravasations of blood sometimes inflames and suppurates, giving vent to grumous blood, leaving behind an ulcerating cavity. Epistaxis, enterrhagia and bleeding from various mucous membranes may take place. Hematuria has also been observed in cases of scurvy in children. It is noteworthy that these hemorrhages are very apt to occur at points where epiphyseal growth is most active.

Hemorrhage beneath the orbital periosteum may produce proptosis and swelling about the eye. Diarrhea is present in some cases. Albuminuria is sometimes encountered in the course of the disease. Formerly scorbutus was most frequently designated as acute rickets. They may occur together. It would not be well to consider all hemorrhagic diseases as scurvy even though hemorrhage is such a prominent symptom of scurvy. Scurvy may even occur in breast-fed infants if lactation be too prolonged.

The triad of symptoms upon which the diagnosis of scurvy may be safely predicted are: first, the swellings and tenderness of the epiphyseal ends of the femur and tibia, secondly, the sponginess, swelling and bleeding of the gums, and, thirdly, the rapid and complete cure under the administration of antiscorbutic treatment. These are at times reinforced by the presence of ecchymoses or petechiæ or hemorrhages from the mucous membranes. Sometimes one of these symptoms is so faint that it is very difficult to make a diagnosis upon them alone, when the therapeutic test solely must decide the question.

Scurvy may be mistaken for acute rheumatism, but in rheumatism the swellings are more apt to be lateral or circumferential, while in scurvy they are longitudinal, cylindrical or fusiform. There is no local elevation of temperature in scurvy, while the reverse is true in acute rheumatism. The joints are red and puffy in rheumatism and white and tense in scurvy. "Growing pains" are usually subacute rheumatism or arthritis and not scurvy. The causes of this trouble are numerous. Our knowledge of this disease may be summarized as follows:

1. It is the result of a faulty nutrition which leads to a deviation from the normal chemical composition of the

blood, probably a deficiency of its alkalinity.

2. The disease is characterized by a blood dyscrasia accompanied by structural changes in the coats of the blood vessels.

3. The bone and joint lesions, the spongy condition of the gums and the petechiæ constitute a triad of symptoms highly pathognomonic of the disease. One or both of the two last-named symptoms may be lacking.

4. The order of development of the symptoms seems to be: first appear the tenderness and swellings of the lower extremity, then the sponginess of the gums, and finally the hemorrhagic extravasations.

5. Under the treatment these symptoms begin to improve in the same order of sequence, the epiphyseal lesions disappearing more rapidly than the other two.

6. If there be any doubt of the diagnosis of a given case, recourse should be had to the therapeutic test of an anti-scorbutic regimen, which will, by its results, in a comparatively short space of time determine the question beyond cavil.

7. The prognosis is nearly uniformly favorable under proper treatment, and the likelihood is that as physicians become more familiar with and competent in diagnosticating the disease, its mortality will be reduced to *nil*.

8. The main principle involved in the treatment of infantile scurvy is comprised in the institution of anti-scorbutic dietetic measures.

* * *

Chronic Anterior Poliomyelitis.—Early in the year, says the London *Lancet*, J. B. Charcot and A. Dutil recorded a case of this character, which was recently abstracted in the *Neurologisches Centralblatt*. The patient was a man of fifty-six, whose illness began in 1890 with weakness in the upper extremities. This was soon accompanied by atrophy affecting the muscles about the shoulder, and also those of the arms and hands, the wasting being most evident in the muscles of the ball of the thumb, in the interrosei, the deltoid, and triceps. The legs were also affected, the wasting showing itself both in the thigh and leg, and there were numerous fibrillary twitchings, but no sensory impairment. The patient died asphyxiated—the respiratory muscles having become involved—about two years after the commencement of his illness. At the necropsy were found (1) chronic anterior poliomyelitis, especially affecting the cervical region, with endarteritis and sclerotic atrophy of the ganglion cells; (2) very slight alteration in the anterior roots, but well marked degeneration of the various peripheral nerves, and (3) in most muscles simple atrophy, while in those in which total or partial reaction of degeneration was present there was wasting of the fibres.

* * *

Amputation without Permission.—According to the London *Lancet* a lawsuit lately took place in Germany in which the father of a girl aged seven years charged a hospital surgeon with assault—to wit: "wounding with a dangerous instrument." The patient was under treatment for tuberculous disease of the foot. Conservative methods of treatment having failed, amputation was advised, but the father refused to give his permission. From a report in a contemporary it appears that the parent proceeded to the institution with the purpose of taking his daughter away, but when he arrived she was under the influence of an anesthetic, which had been administered with a view of amputating the foot. The surgeon in charge, on being apprised of the purport of the father's visit, is said to have remarked, "It is too late," and proceeded to amputate. There can be no doubt, if he was aware of the father's objection to the operation, the course he took was wrong both on legal and ethical grounds. When a mutilating operation is necessary to ward off impending peril of death, it would be absurd to have to wait for permission to resort to it, but in the case under consideration no such circumstance can well have arisen. The liberty and rights of the subject cannot be allowed to be overridden. Nevertheless,

there may be much to extenuate the offence, and we cannot imagine greater mitigation than where there is conflict between a surgeon's judgment and a parent's feelings. The surgeon in question was acquitted, but it is said the cause is to be retried.

* * *

The Nerve Regulating Lacrymal Secretion.—In the *Revue Neurologique* a paper by Jendrassik has lately appeared, in which he asserts, on the evidence afforded by careful clinical observations, that the so-called lacrymal nerve is not the nerve that subserves the secretion of tears, but that this is the junction of a part of the facial nerve. Goldzieher arrived at the same conclusion some time ago. The following, according to Jendrassik, is the way in which the fibres of the facial nerve which serve this purpose reach their destination. They leave the main trunk of the nerve at the level of the geniculate ganglion and run in the superficial petrosal nerve to the spheno-palatine ganglion. From here a part of the fibres goes to the palate, another part, after crossing in the second branch of the fifth nerve, to the orbital nerve which goes off from the trigeminal at the level at which the facial fibres enter. Immediately in front of the lacrymal gland the orbital and the lacrymal nerves unite and from this united trunk the secretory nerves are transmitted into the gland. No doubt the acceptance of such a statement as this would explain some peculiarities in connection with facial paralysis, but it would seem to imply that the facial nerve also supplies the palate. Against this, as is well known, the evidence now is practically overwhelming.

* * *

The Role of Bacteria in Butter-Making.—Professor H. W. Conn and Mr. Wm. M. Esten, following up the investigations of Storch, Weigmann, Adametz, and Wilckens, have carried on a series of experiments, which are recorded in the London *Lancet*, on the ripening of cream for butter-making by artificial cultures of bacteria, the results of which are given in the Sixth Annual Report of the Storrs Agricultural Experiment Station, issued this year. The importance of the subject is so great that a prize of considerable value was at one time offered to any one who could place in the hands of dairymen a culture of a bacterium or of a mixture of bacteria which, added to cream, would set up the peculiar fermentation through which the cream must go before it is churned into good butter. Up to the present no one has been completely successful in obtaining satisfactory results; but from this report it is evident that these American workers have succeeded in separating out organisms which so far ripen cream in the proper manner that, although not one of the species examined would when used alone for ripening cream produce a typical flavored butter, "many of them produce butter which is excellent in flavor and which was preferred to that of the normal ripening." Out of a large number of organisms separated no fewer than fourteen were used, whilst, in addition, the bacillus acidi lactici, the micrococcus freudenreichei, the bacillus katz, and the bacillus schafferi produce a butter ripening fermentation, but not so good as that obtained from the use of some of the organisms obtained from the creameries. Professor Conn maintains that, if the organisms be obtained from sour cream in a dairy that has a reputation for making good butter they in turn will give good results, the converse holding good that organisms from a bad dairy will produce bad butter. The experiments with mixtures of the different organisms are not yet completed, but it is probable that by combining the action of several micro-organisms an even finer flavor may be obtained in butter made from cream ripened by these artificial cultures. Preliminary heating of the cream to 70° C. (158° F.) prepares the way for the growth of the inoculated bacteria, killing off most of those bacteria that are accidentally present and which often disturb the ripening process. The preliminary heating to 70° C. (158° F.) is of further importance from the fact that so many of the disease germs succumb when exposed to this temperature. One great advantage of this method is that the process may be made

to extend over a somewhat longer period than is usually found necessary in dairy operations. In fact it can be controlled much more accurately than the natural ripening process. The bacteria may be kept alive and active for some time, so that, a good stock having been obtained, a certain flavored butter can always be at command.

* * *

Influenzal Otitis.—During the epidemic of influenza in 1889-90, Dr. Laurence Turnbull reports to the Philadelphia *Medical and Surgical Reporter* that he treated a large number of ear cases in which earache followed by acute otitis media and often perforation were the prominent symptoms. They were not easy to treat. Since that time he has seen sporadic cases of the same kind. His conclusions from these cases are:

First. There is a peculiar inflammation of the ear termed influenzal otitis.

Second. It almost always commences with hemorrhagic, dark blue or black bullæ seen in the lower posterior segment of the membrana tympani.

Third. After a time a perforation of the membrana tympani takes place with a discharge of bloody muco-serous fluid.

Fourth. The pain, which is severe before the perforation, is not entirely relieved by it and continues, assuming more of a neuralgic character. There are subjective noises (tinnitus aurium) such as pounding, hammering and roaring, and if not properly treated by inflation or by Politzer's douche or the catheter, remain after all the inflammation has ceased.

Fifth. Fatal results may follow from meningitis, abscess of the brain, and more frequently sinus phlebitis. Such cases we are called upon to diagnose, being sent to our clinic as abscess of the brain.

* * *

Vaginal Hysterectomy without Clamps or Ligatures.—That vaginal hysterectomy may be performed without clamps or ligatures, Dr. Emory Lanphear asserts very boldly in the *Cincinnati Medical Journal.* He recently did four cases and they were almost minor operations. His method is as follows:

After proper preparatory treatment, the vulva is shaved and carefully scrubbed, and the surrounding surfaces covered with towls wrung from bichloride solution, 1 to 2000. The vagina is cleaned by thorough douching with very hot water, scrubbing and irrigation with hot bichloride solution. The perineum is pulled back with a strong retractor and the cervix seized with a vulsellum and pulled to the outlet or near it. The cervical canal is gently curetted and packed tightly with iodoform gauze. Once more the vagina is cleaned, a solution of carbolic acid 1 to 40 being preferable. The mucous membrane surrounding the os is cut with a knife, the incision completely encircling the cervix at a distance of about one-half of an inch from the cervico-vaginal junction. Without much force the tissues are separated by means of the points of blunt scissors. It is necessary to use the blades of the scissors at some places, clipping fibres here and there where too firmly attached to be easily torn through; but as little cutting as possible should be done, the prime object of the operation being to enucleate the uterus by entering the loose tissue surrounding it, the tissue in which the terminal branches of the uterine artery ramify, and by careful work to denude the uterus of its areolar tissue, pressing aside every important blood vessel uninjured. The only points where separation cannot be quickly done are at the internal os, where the connective tissue is quite dense, along the sides of the organ and at the entrance of the Fallopian tubes. As the uterus is peeled from its enveloping tissues it must be strongly pulled downward; by so doing the peritoneum covering the fundus can be easily pushed off by the fingers.

When enucleation is completed the vagina is cleaned, the cavity packed rather tightly with iodoform gauze, and the vagina lightly tamponed with the same; the packing must be done with some care, as rough manipulations may cause serious hemorrhage. If the operation be done slowly and the peritoneum be pushed aside instead of being cut there should be no bleeding. From his

experience he believes that enucleation as performed in his four cases is the ideal method of vaginal hysterectomy, and he concludes as follows :

1. The loss of blood is trifling, and as the vessels are not injured they remain to repair the wounded parts, which they do with rapidity and completeness.

2. Diseased tissue is not disturbed, the uterus not being mutilated or even wounded, the entire organ being removed intact.

3. If by accident a blood vessel is cut it is so perfectly in the field of operation that it can readily be secured by forceps and tied without injuring the neighboring nerve fibres.

4. There is no pinching of the sympathetic and spinal nerve fibres by clamps or ligatures ; consequently there is no "shock" following operation.

5. When necessary the tubes and ovaries can be removed with no loss of blood, and the peritoneal opening closed as perfectly as in celiotomy, preventing hernia and leakage of discharges into the pelvis.

6. The operation seems almost devoid of shock or danger to the patient—practically converting a major operation into a minor one.

7. It possesses none of the bad features of vaginal hysterectomy by the clamp or ligature, viz. : high death rates, slow convalescence, and disturbances due to pressure.

8. There is scarcely any pain and very little soreness after the operation ; the reaction and healing are rapid ; the freshness and buoyancy of the patients are restored to them, and their natures, instead or being changed for the worse, are radically improved by the work.

* * *

Pseudo-Bulbar Paralysis.—Dr. W. S. Colman has recorded in *Brain* a case of this interesting condition (London *Lancet*). The patient was a man aged forty-nine who, a year before his admission to hospital, was noticed to drag his left leg in walking. This weakness passed off sufficiently to allow him to resume his occupation, but it recurred and rendered him quite helpless. Six months later there was some difficulty with articulation, and a few months later difficulty in swallowing and a simultaneous affection of the right leg occurred, rendering it as useless as the left. There was also an alteration in his mental condition, so that his laughter and tears were alike uncontrolled, but there were no hallucinations and no true aphasic difficulties. When he came under observation he was in this peculiar physical state, ready to laugh or cry on the slighest provocation. He complained of loss of memory and he was dull and confused, and his articulation was very imperfect. The face, arm and leg muscles were all weak, the weakness being more marked on the right side than on the left. The knee-jerks were exaggerated and ankle clonus was present on both sides and the jaw-jerk was also present. The tongue could only be protruded as far as the lips. There was no obvious wasting of it and no fibrillary twitching. The movements of the soft palate were impaired, and they afterwards became completely abolished. There was no sensory impairment. The patient died from bronchitis and at the necropsy the vessels at the base of the brain were found to be atheromatous. Degenerated fibres separated by normal bundles were found in both internal capsules, and in the right one was a patch containing hematoidin crystals, evidently the remains of an old hemorrhage. Many of the small arteries in the neighborhood were completely thrombosed. Descending degenerations could be traced throughout the whole length of the cord in the crossed pyramidal tracts and as low as the third dorsal root in the direct pyramidal tracts. The cells of the hypoglossal nuclei and of the anterior horns were not diminished in number or changed in appearance. The case is an interesting one, as showing how closely such a condition simulates bulbar palsy. The same close resemblance has been evident in similar cases recorded by Barlow, Lepine, Hughlings Jackson and Taylor, Ross, and others, and, as Dr. Colman points out, it must always be difficult, although we would hardly admit impossible, to diagnose the one condition from the other. The three points

which Dr. Colman emphasises as important in diagnosis will, we think, generally be found sufficient. These are the usually asymmetrical nature of the limb affection in the cases of double hemiplegia, the absence of any marked wasting of the tongue, and the preservation of its electrical excitability.

* * *

Free Hydrochloric Acid in the Stomach in Chlorosis.—Osswald, of Riegel's Clinic, in the *British Medical Journal*, first draws attention to the discordant views on this subject. It is an important matter that similar diet should be used in these investigations. It is thus found that the amount of free hydrochloric acid present after Ewald's test breakfast is less than after Riegel's test meal; the former contains less albuminous material. For the former a percentage of above 15 to 25, and for the latter above 3, should be looked upon as hyperacidity. Apparently the amount of free HCl present would seem to vary with the district, owing, perhaps, to different diets. In his investigations the author estimated the amount of free acid by trituration with a 1 in 10 normal soda solution, phenolphthalein being the indicator. Digestion tests were not used, for it is mostly found that in the presence of free HCl the digestive powers are good. The author has made 84 investigations on 21 patients suffering from chlorosis, dividing them into those with slight and those with severe dyspeptic symptoms. There was no sufficient reason to think that gastric ulcer was present in any of these cases. In all instances free hydrochloric acid was found in excess. The motor power of the stomach seemed to be efficient. The author is not disposed to attach much significance to the question of gastric dilatation in chlorosis. In 5 cases Martin's test was applied for the purpose of finding out the total hydrochloric acid acidity. Attention is drawn to the difference then found between the total acidity estimated by the method aforesaid and the HCl acidity according to Martin's method. In regard to treatment, the author thinks that where iron has been given without result the alkaline treatment should be adopted. Often considerable improvement may thus be obtained, but it cannot always be said with certainty whether it is due to the alkalies. A mixed diet containing proteid matters should be used. The author concludes that the amount of hydrochloric acid present in the stomach contents in chlorosis is not diminished but very often increased (in 95 per cent. of the cases). The dyspepsia is not due to hypo- or anachlorhydria nor to motor insufficiency on the part of the stomach. Thus, any views which make chlorosis depend either entirely or in great measure upon the diminution of the free hydrochloric acid present in the stomach cannot be vindicated.

* * *

Tuberculous Iritis.—Vignes (*British Medical Journal*) calls attention to the phenomena of inflammation in the iris preceding the formation of tuberculous nodules in that structure. The period of duration of this inflammation he distinguishes clinically as that of tuberculous iritis from the period of nodular growth of tubercle in the iris. This premonitory inflammation may precede the formation of nodules many weeks; its method of onset is very insidious, its evolution is torpid, there is very little inflammatory appearance, but a large number of dense synechiæ are present. The absence of pathognomonic signs makes the diagnosis very difficult. It may undergo spontaneous cure without the formation of nodules; this tendency towards cure depends on individual resistance, and especially on resistance of the iris itself. This power of resistance, as has been demonstrated on animals, is very great, and has probably more to do with spontaneous cure of the disease than attenuation of the bacillus or its toxins.

* * *

To Preserve Urinary Casts.—For preserving urinary casts without objectionable coloring, the best method is to employ a mixture of alcohol, glycerine, and water, in equal proportion. Even in warm weather, by such a mixture, we are enabled to keep casts for several months.

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See Publishers' Department, Page 356.

BALTIMORE, AUGUST 18, 1894.

Post-Mortem Changes in Insanity.

STUDIES made at the post-mortem table and in the pathological laboratory of cases have thrown much light on certain obscure conditions and thus have been of great help in treating diseases. But there are some cases in which the morbid changes can hardly account for the diseased state through life. This Dr. H. A. Tomlinson shows in the *University Medical Magazine*, when he speaks of the inadequacy of the morbid changes found post-mortem to explain the manifestations of insanity.

The trouble seems to be that up to the present time attention has been turned principally to the amelioration of the condition of the insane and their careful housing and separation from their friends. The effort was made to study the earlier manifestations of the disease but no systematic study of the disease as it first appeared. The error seems to have been that the lesions producing insanity, like lesions elsewhere, may be defined and localized. In dealing with insanity we have to do not with a tangible entity, but with the manifestations of a perverted function having no material qualities. There is no abstract difference between the sane and the insane. The difference lies in the motives which actuate the conduct and this condition is found in the nervous tract.

From a series of cases studied, it is very evident that in the pathology of insanity we have to deal with alteration, not destruction, of function. It is possible, however, that there can be a chemical imperfection of structure even where there is no morphological imperfection present and this may be the starting point for any erratic or insane action.

Again, under the influence of fatigue, mental strain or bodily illness, disease in the motor or sensory nervous tract may be carried to the central nervous system. Impaired nutrition may also be at the foundation of these attacks. That this whole subject is rather vague no one will deny and yet it may be possible to draw from these studies inferences, which although theoretical, are of scientific value. Dr. Tomlinson says:

It would seem to be a fair inference, if the experience of others bears out the deductions I have made, that the greatest advantage to be gained from post-mortem studies in the insane lies in the discovery of the influence which diseased conditions in the different organs of the body have in the determination of insanity in those predisposed, even where these conditions have no appreciable influence on the general health of the individual, but show their effect principally in the production of autoinfection, which in its turn determines the temporary or permanent breakdown of an unstable nervous organization.

* * *

Dissatisfied Human Nature.

ONE problem that constantly confronts the practicing physician is how to make lean persons stout and stout persons slender. If there could be a system of "give and take" or if there were a clearing house where excess and lack of avoirdupois could be regulated, probably human nature would find something else of which to complain.

As it is, many go through life weighed down with fleshly burdens grievous to be borne and still others would gladly add to their weight provided the addition could be de-

posited in the right place, and so all are dissatisfied. In fact this is usually a case where prevention is better than cure or in which the simplicity of the cure does not appeal to the average human being. The stout woman wishes her waist reduced and her neck enlarged; the obese man would gladly part with a few chins and a protuberant abdomen, but neither is willing to give up pet habits or favorite foods and stimulants.

The woman may continue to devour large quantities of sweets, and the baser sex may consume rich foods and fattening stimulants, yet neither is willing to part with what delights the palate, but seeks some drug which will counteract this overfeeding, and the poor medical man is taunted with the statement that he is powerless to cure trifling ailments. Some persons will grow stout in spite of everything, while others remain skeletons against all endeavors to the contrary.

Could implicit obedience be had from these sufferers, no doubt much might be done through diet and exercise. But it is very difficult to induce the wealthy woman to give up her carriage and take to walking, and the thin one will have her pleasures and excitements despite all advice to the contrary. Physicians in general practice have great difficulty in dealing out flesh to satisfy all.

It is true that greater efforts are made to reduce than to increase the weight because this increase is accompanied with greater dangers; both conditions can be changed with some exceptions, not by home treatment, but by strict care and supervision in a hospital where all food and exercise can be regulated. The exceptional cases, however, will go on unaffected by any known treatment, probably because in each case there is a greater or less activity of the powers of assimilation beyond the control of even the best medical aid.

Physicians can and should give more attention to these disfigurements which demand the best skill and treatment even if they are not considered diseases.

* * *

Too Many Medical Societies?

Local medical societies undoubtedly accomplish much good when they are full of life and the members take part willingly. State societies are absolutely necessary even if they hold but one meeting a year. But it is a question if the numerous congresses, national and international, which are so rapidly increasing in number and are meeting at every available place and time, really do the good that was originally intended. The scientific good resulting from such meetings is very often infinitesimal and much of the time is taken up with excursions and general amusements. With a growing tendency towards specialism, each specialty wishes to have a representative society, but they would do just as well with occasional meetings and with a limited number of papers. Certainly the profession would be much better repaid with a few good papers followed by intelligent discussion than with hearing long papers burdened with tiresome historical references.

* * *

Anesthetics in Examinations.

Of late quite a number of articles have been written on the necessity for the use of anesthetics in making examinations of one and another part of the body. It seems strange indeed that pages, and even books, should be written to prove what is a foregone conclusion. In gynecology, for example, there is no satisfaction in examining for certain obscure troubles when the patient is shrinking with fear and pain and the assistants have difficulty in keeping her in position.

In diseases of the rectum, anesthetics are especially necessary, for here the mucous membrane is very sensitive even in health, and in a condition of disease it is well-nigh impossible to examine satisfactorily, and it would occur not only to the specialist but even to the general or country practitioner that a better examination could be made when the patient is unconscious than while experiencing all the pain and discomforts of an examination.

Such a proceeding as the use of anesthesia appeals to the common sense of the surgeon and no amount of literature is needed to convince him of what his sense tells him in the beginning. Therefore if medical literature would teach let it at least pass by what "goes without saying," as the foreigner says, and let it deal with new matter or with good cases, but not truisms.

* * *

China has the plague, the cholera and the war, and none of them is abating.

MEDICAL ITEMS.

Cholera has spread in Europe.

Small-pox has broken out in Milwaukee.

Dr. Hunter McGuire has gone abroad for the month of August.

Dr. Edwin Geer has removed from Park Avenue to 1533 Bolton Street.

Dr. James T. Whittaker, of Cincinnati, is spending the summer in Europe.

Dr. Henry J. Berkeley is spending the summer abroad engaged in some special work.

Mr. William Hooper, of Cincinnati, died recently and left large bequests to hospitals of that city.

Dr. George Byrd Harrison was elected president of the Medical Association of the District of Columbia.

In Cincinnati most of the physicians live in one neighborhood, and many are together in large office buildings.

Dr. D. Mayer, of Charleston, West Virginia, has been elected president of the Medical Society of West Virginia.

The next International Medical Congress will be held at Moscow and not at St. Petersburg as previously stated.

The Twenty-fifth Annual Session of the Virginia State Medical Society will be held at Richmond, October 23, 1894.

By the will of the late Mrs. Whiteford, of Baltimore, the City and St. Joseph Hospitals each gets five thousand dollars.

Many emergency cases were treated in the month of July at the Central Dispensary and Emergency Hospital of Washington.

The Sterilized Milk and Ice Society has been organized in Philadelphia to supply ice and milk to the needy at a nominal charge.

Mrs. D. Hayes Agnew has given $25,000 to the University Hospital of the University of Pennsylvania, in honor of her late husband.

The disinfecting plant for Baltimore's quarantine station is completed and will be turned over to the city as soon as it has been tested.

Dr. H. L. E. Johnson, in charge of the Department of women's diseases in the Medical Department of the Columbian University of Washington, D. C., has organized a maternity service for the purpose of giving clinical advantages to medical students and young graduates.

The Boylston Medical Prize for 1894 has been awarded to Dr. Norman Walker, of Edinburgh, Scotland, for an essay entitled "The Histological Varieties of Cutaneous Cancer."

In France the public schools are supplied with sterilized water for the scholars and the floors are cleansed with a moist cloth and not with dry dusters and brooms, as was the custom heretofore.

Dr. John B. Hamilton, the editor of the *Journal of the American Medical Association*, announces that the report that he is a candidate for election to Congress is entirely without foundation.

After much trouble the City of Chicago has just bought a tract of ten acres of ground, on which to erect a contagious disease hospital, and elaborate plans are being prepared for a model construction.

The *New York Journal of Obstetrics and Gynecology* will hereafter be called the *American Gynecological and Obstetrical Journal*. This may lead to needless confusion with Dr. Mundé's excellent monthly.

The physicians of Berlin, like those of New York, are provided with a card, giving them the right of way through the streets and to prevent unnecessary delay by a fire or other obstruction. This only applies when they are in the discharge of their duty.

The city of Allegheny is said to obtain its drinking water from the Allegheny river at a point where sixteen sewers discharge their contents. This, together with the fact that the city has no municipal system of garbage removal, makes it one of the most unhealthy cities of this country.

A physician from a small town in Louisiana relates in the *Louisville Medical Monthly* how he studied the circulation and the organs in a frog that had swallowed a firefly, which continued to glow in its host's body and thus illuminated his body through the transparent skin. Vivid imaginations flourish in some places.

According to an estimate made by Dr. John K. Scudder, an eclectic physician of Cincinnati, there are 2,120 physicians in Maryland, of whom 1,606 are put down as regular, 76 homeopathic, 24 eclectic and 212 unclassified. There are over nine thousand homeopathics and over ten thousand eclectics in the United States.

BOOK REVIEWS.

A HANDBOOK OF MEDICAL MICROSCOPY. For Students and General Practitioners, including Chapters on Bacteriology, Neoplasms, and Urinary Examinations. By James E. Reeves, M. D., Member of the Association of American Physicians; Ex-President of the American Public Health Association, etc. With a Glossary and Numerous Illustrations (partly in colors). Philadelphia: P. Blakiston, Son & Co., 1894. Pp. xv–17 to 237. Price, $2.50.

If anyone had ever doubted the importance of medical microscopy, he would be fully convinced after reading and using Dr. Reeves's eminently practical work. It is prepared and written from the standpoint of a man who has worked in this department for over forty years and has proved each step himself and the beauty of whose microscopical preparations every one admires. The book opens with a chapter on the importance of the microscope in medicine, and then follows a section on how to work, with directions concisely but clearly given on preparation of tissue and mixing of stains. The section on bacteriology is extremely satisfactory to one who knows already something of that department of medicine. What is especially good is the chapter on urinary examination. Not only are the directions plain and in order, showing them to emanate from a man who has frequently done this work himself, but the illustrations are well chosen and abundant. It is a book which will be much used and a great help as a clinical aid. It is needless to say that the publishers have taken pains to bring out a typographically perfect work and the care with which the illustrations are reproduced evidences this. The glossary may be of use to many persons unfamiliar with ordinary terms.

REPRINTS, ETC., RECEIVED.

The Surgical Use of Cocaine. By B. Merrill Ricketts, Ph. B., M. D., Cincinnati.

Circumcision. The Last Fifty of a Series of Two Hundred Circumcisions. By B. Merrill Ricketts, M. D., Cincinnati. Reprint from the *New York Medical Journal.*

Should the *Journal of the American Medical Association* be Used to Promote Quackery? By Solomon Solis Cohen, M. D., Philadelphia. Reprint from the *Transactions of the Medical Society of the State of Pennsylvania.*

CURRENT EDITORIAL COMMENT.

THE CONTEST WITH MORBIFIC GERMS.

New York Medical Journal.

IT must be borne in mind that man enjoys immunity from many germ diseases which certain of the lower animals are subject to; the principal thing is to find out which animal is proof against particular germs, and employ that animal, or a part of it, or a secretion of it, or something artificially prepared from it, to fight those germs.

THE COLLEGE CATALOGUE SEASON.

The Cincinnati Lancet-Clinic.

THE great interior States have been great feeders for Eastern schools, Eastern practitioners, and Eastern publishers. Rapid transit of news and knowledge should level these conditions until there should be found in Cincinnati, St. Louis and Chicago not only great endowed medical colleges, but authors and publishers. Such conditions are demanding attention, and must have a solution in a new life which we hope is dawning upon us.

PROPRIETARY MEDICINES.

The Cincinnati Medical Journal.

IT is a waste of powder to make war on any proprietary preparation used by the profession. If it has no merit, if its pretensions are fraudulent, the physician will let it severely alone, and if it is in continued demand such proof positive of its clinical value will render harmless all attacks against it. The preparations of long established and successful pharmaceutical laboratories are therefore to be depended upon, and the physician may feel reasonably certain of the truth of what the manufacturers claim.

THE PHYSICIAN AND THE SURGEON.

North American Practitioner.

WITH some degree of satisfaction we can survey the domain of surgery and feel confident that the time will come when surgical successes will have reached their utmost limit; but when we attempt to compass the field of medicine, or seek the confines of medical study, the labor incident to their mastery seems well-nigh appalling. The final shore lines will doubtless never be within our vision. But by so much as a greater skill and labor shall bring these mysteries to the knowledge and service of men, by so much the more, we believe, in the final estimate, the physician is destined to outrank the surgeon.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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TO PRACTITIONERS OF MEDICINE.

The Medical Law as repealed and re-enacted, with additions and amendments, by the Maryland State Legislature, has been printed at this office in neat and convenient form for physicians. Copies may be obtained at the Journal Office or will be forwarded by mail on receipt of 15 cts. in stamps or coin.

NOTES.

CHLORALOSE is an active drug but should be used with great caution, as it may cause poisonous effects.

*

ICHTHYOL-AMMONIUM suppositories, thirty to forty-five grains with cacao butter twice a day, are very efficacious in prostatitis.

*

EQUAL parts of guaiacol and glycerine painted over the surface of the skin in sciatica and intercostal neuralgia gives prompt relief.

*

BICARBONATE of potash, given hourly in ten-grain doses, is said to dissipate the disagreeable toxic effects sometimes produced by iodoform.

*

TWO or three tablespoonsful of brewer's yeast taken in the twenty-four hours before eating, mixed with beer, is said to cure carbuncle or boils promptly. Diarrhea may be produced by this treatment, but it does not occur often.

*

IODIZED collodion has been recommended as an excellent depilatory. The formula is:

Alcohol	48 parts
Iodine	3 parts
Collodion	140 parts
Oil of turpentine	6 parts
Castor oil	8 parts

This is to be applied to the hairy parts every day for three or four days.

READING NOTICES.

Loretin.—In certain industries in which extreme and varying temperatures and excessive dampness or dryness have caused troublesome skin irritations, Loretin has proved itself a very excellent, soothing and healing medium. The chapped or irritated parts of the skin are either bandaged over night with a 5 per cent. Loretin gauze, or preferably, are rubbed with a 5 or 10 per cent. Loretin talcum powder. All itching of the skin disappears at once. This treatment has also proved effectual in cases of eczema.

*

Hæmoferrum.—Physicians who employ iron in their practice should be greatly interested in a new iron preparation recently introduced to the medical profession by Frederick Stearns & Co., Detroit, Mich., called Hæmoferrum (Blood Iron). This is a natural proteid compound aseptically prepared from fresh bullock's blood, and put up in 3 grain pilloids (flat pills), with a highly soluble coating. F. Stearns & Co. claim their Hæmoferrum to be free from all the objectionable features hitherto attending the administration of iron in other forms, it being extremely soluble, pleasant to the taste, agreeable in odor, is readily and easily assimilated, and neutral in reaction. Furthermore it is non-constipating (a valuable characteristic), non-irritating and non-poisonous, even in large doses.

*

Salophen.—Recently Dr. W. A. Galloway (*American Therapist*, April, 1894) has called attention to what, he thinks, may be a new and valuable use of Salophen. In four cases of septic infection which came under his observation within the past two months, an exhibition of gr. v. Salophen, every four hours, brought the septic process under complete control within four days. Case 1 was a traumatic pyemia, which grew steadily worse under quinine, iron and alcohol, periostitis of long bones was marked, as were also the cerebral symptoms. Case 2. Septic infection from metastatic abscesses in axillary glands; cause, trauma. Cases 3 and 4 were puerperal sepsis. These excellent results from the exhibition of Salophen alone in the above cases led Dr. Galloway to believe that a more extended trial should be given the remedy in the treatment of septic infections. Aside from these prompt curative effects Salophen has the further advantages that it is tasteless, will not irritate the stomach, and is perfectly free from after-effects.

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ORIGINAL ARTICLES.

SURGERY OF THE GALL-BLADDER.

READ BEFORE THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

By X. O. Werder, M. D.,
Pittsburg.

THERE are practically only two operations to be considered for the relief of cholelithiasis, the most common affection of the gall-bladder requiring surgical interference, namely, cholecystotomy with suture of the edges of the gall-bladder to the abdominal wound and cholecystenterostomy. Cholecystectomy, on account of the greater mortality attending it as compared with these two other operations, is, in my opinion, only applicable in malignant disease of the gall-bladder, or when this viscus has become so contracted as to make either of the two other operations technically difficult or impossible. Cholecystotomy, with complete closure of the incision and return of the gall-bladder into the peritoneal cavity, still advocated by some operators, and called "ideal cholecystotomy," is equally objectionable for the same reason of greater mortality.

Generally speaking, the technique of both operations, cholecystotomy and cholecystenterostomy, has been so much improved and the results of either proven so satisfactory, that a kind of rivalry has arisen between them ; and since the introduction of the "Murphy Button" it almost seems as if the latter was destined to supersede the former. The principal reason of this is the fact that cholecystotomy is not infrequently followed by a permanent, or at least a long, persisting fistulous opening between the gall-bladder and abdominal wound, accompanied by a more or less constant stream of bile pouring over the abdomen, which is not only a source of annoyance to the patient on account of the inevitable soiling of the clothing and by giving rise to eczematous eruptions and dermatitis, but it may, when the greater portion of the bile is turned out of the system through this external sinus, become a serious menace to health and the life of the patient, because a certain quantity of bile, as we know, is necessary to carry on the digestive functions properly.

By means of the "Murphy Button," cholecystenterostomy has not only become a remarkably simple and easy operation, but judging from the uniformly successful results published within the last few months, it appears to be one of the safest operations in abdominal surgery. It is, therefore, not at all surprising that Murphy, the ingenious inventor of the anastomosis button, and his followers have been decidedly partial to cholecystenterostomy in all cases in which operation is indicated, when we consider that both operations are about equally safe, and that the latter has the advantage that it does away with the not uncommon sequela of a biliary fistula and establishes at once a new chan-

nel from the gall-bladder into the intestinal canal, through which even the largest calculi find a ready passage into the bowel, and that it obviates the necessity of scrupulously searching the common duct for any obstruction for the purpose of removing it. I am not aware of any unpleasant after-effects in the cases operated on, up to the present, but the operation is a new one, and the patients have scarcely been under observation a sufficient length of time to allow of any definite conclusions. It seems a matter of considerable importance to me, to make the anastomosis as closely to the normal communication, by means of the common bile duct, as possible. For this reason the duodenum, or, at least, the upper portion of the jejunum, should be selected. If, for some reason, this part of the intestine cannot be brought into view, as happened to me in case No. III, cholecystotomy, at least in uncomplicated cases, seems preferable.

The cases reported in this paper are three cases of cholecystotomy and one case of cholecystenterostomy, all followed by recovery. The operation of cholecystotomy was performed in two cases for cholelithiasis, the number of calculi removed being in one case twelve, in the other sixty-eight, varying in size from a pea to a hickory nut; in the other for empyema of the gall-bladder. Cholecystenterostomy was done for a permanent biliary fistula with, at least, a partial obstruction of the common bile duct, probably due to a stenosis and adhesions. In two cases (Nos. I and II) the gall-bladder was completely surrounded by omentum and intestines, so that it became necessary to free some of these adhesions from the anterior surface of the gall-bladder before it could be incised. In both of these cases the walls of the gall-bladder were very much thickened, in one (No. I) not less than three-quarters of an inch, and strong suspicions of malignancy were entertained at the time of the operation, but the patient, now over a year since her operation, is in perfect health.

Case I.—Mrs. R. W., aged thirty-nine years; seven children, youngest one year. During her last pregnancy had two, three, or more paroxysms of pain in right hypochondriac and epigastric region. After her confinement, October 15, had no attacks until the beginning of April, 1892, when they returned at intervals of from four to six weeks, and during the three to four months preceding the operation, these paroxysms came on every week, sometimes even two or three times a week, keeping her confined to bed half of her time. I saw her for the first time six or seven weeks before her operation, when she was suffering from an attack of local peritonitis, compelling her to remain in bed about two weeks with elevation of temperature to 101°, vomiting, tympanitis and icterus. Over the region of the gall-bladder a mass could be mapped out exceedingly tender, about three inches long and one and a half wide.

Operation March 22, 1893, at Mercy Hospital. Vertical incision three inches long over seat of tumor; this was found completely covered with omental and intestinal adhesions, which had to be separated in front of the gall-bladder before it could be incised. Walls of gall-bladder about three-quarters of an inch thick, exceedingly friable, so that sutures would scarcely hold, suggesting malignancy; they were sutured to abdominal incision. Ducts were found unobstructed. Sixty-eight calculi of various sizes were removed. Rubber drainage introduced and gall-bladder washed out. Fistulous opening closed on tenth day, and patient has remained in perfect health ever since.

Case II.—Mrs. Agnes K., referred by Dr. J. C. Hierholzer, aged fifty-three, was suffering for seventeen or eighteen years from attacks of burning and tearing pains in the hepatic region, with vomiting at intervals of various duration and treated by different physicians for pleurisy, bilious attacks, neuralgia, etc. Present illness began in March, 1893, with severe pains of paroxysmal character, irregular elevations of temperature, dry tongue, constipation, very severe headache and no jaundice. Marked tenderness over region of gall-bladder, which was distinctly enlarged, reaching

about four inches below border of ribs. Operation July 3, 1893, at Mercy Hospital. Usual incision exposed gall-bladder surrounded by omental and intestinal adhesions; these were broken up over anterior surface to make room for incision. Walls of the gall-bladder very much thickened; sutured to abdominal wound; gall-bladder contained several ounces of mucus and pus, but very little bile and no calculi. Rubber drainage tube inserted and gall-bladder washed out daily. Discharged from the hospital completely relieved, but with biliary fistula which closed completely three or four months after operation. At present she is in perfect health; she has a small hernial protrusion at side of operation. This case is interesting on account of the history of biliary colic extending over seventeen or eighteen years, with attacks of local peritonitis and a beginning empyema of the gall-bladder without a trace of any calculi.

Case III.—Mrs. D., aged twenty-nine; for over a year had paroxysms of intense pain in epigastrium and right hypochondrium, lasting for a few minutes to several hours, accompanied by vomiting. During the last few months these have returned at shorter intervals, sometimes daily, scarcely less than two or three attacks a week, so that her general health began to fail. Occasionally her conjunctiva was slightly icteric, but there was never any distinct jaundice. The region of the gall-bladder was examined repeatedly, but while always tender to the touch, it was never found enlarged. Repeated examinations of stools proved negative. Her condition became so miserable that we at least decided to explore the gall-bladder. Operation was performed January 28, of this year, at the Mercy Hospital. Gall-bladder not enlarged and free from adhesions, considerably distended with almost clear fluid. Ducts were free. Wound in gall-bladder attached to abdominal wound and twelve large, hard gall-stones, without any facets, but with rather sharp points, removed. Left hospital February 24, still discharging bile. Discharge gradually lessened, biliary fistula closing up completely for a few days at a time, then opening again, but is now completely healed. She has gained flesh since the operation and is in good health, but is troubled with flatulency, giving her some pain in the epigastrium, which is, however, immediately relieved after a free eructation of gas.

Case IV.—Miss Bella F., aged twenty-five. Admitted to the Mercy Hospital, April 3, 1893; service of Dr. C. O. Goulding, with the diagnosis of typhoid fever. As typhoid fever, the case was of more than ordinary severity, the temperature reaching 103 and higher for eleven days. April 16, patient was seized with severe pain in epigastrium, followed by vomiting for twenty-four hours. A tumor was noticed two days later in the hypochondriac region, somewhat the contour and about the size of a kidney, not very tender on pressure. During the next few days, tenderness over tumor increased and pains of a lancinating character were complained of. Temperature and pulse still increased.

April 26, under ether narcosis, Dr. C. O. Goulding made an incision over the region of the tumor, which, when exposed, was of a livid color, deeply congested, of oblong shape and fluctuating, extending down nearly to iliac fossa. Not adherent at point of incision, but slightly adherent to abdominal wall over limited area below. Tumor was not incised, but wound was packed with iodoform gauze.

April 28, two days later, during which time patient's condition had somewhat improved, the tumor was opened and about half a pint of viscid, semitransparent fluid containing pus was removed.

May 1, great amount of biliary fluid discharged since; removed several fragments of gall-stones. Several other stones were removed at varying intervals, the fistulous tract gradually growing smaller in the meantime.

June 5, sinus dilated with laminaria tent and several stones removed; some days later a stone was found occluding cystic duct as shown by a continuous discharge of considerable mucus, but no bile; stone was located three and a half inches from external opening, but

all efforts to remove it by forceps or irrigation proved useless.

July 12, she was again anesthetized, fistulous opening enlarged in line of old cicatrix one and a quarter inches. Efforts at extraction failing, the stone was crushed and fragments removed. It was not faceted, almost round, diameter about three-quarters of an inch. Wound was packed with gauze and allowed to heal by granulation. Bile discharged freely after operation. Patient's condition much improved and gained in weight. Fistula was almost closed and patient allowed to go out of the hospital August 24, continuing under observation. For above notes, I am indebted to Dr. C. O. Goulding, her attending physician.

Cholecystenterostomy: Above patient was readmitted to Mercy Hospital, September 8, and through the kindness of my friend and colleague, Dr. Goulding, transferred to my department. Biliary fistula has been discharging a great deal of bile since leaving the hospital, and she is complaining of considerable pain and tenderness over the region of liver and gall-bladder and is constipated. She is very anxious to be relieved, not only of her biliary fistula, but of her pain, which is more or less constant, and keeps her awake at night. For this reason, after the usual preparations, an exploratory incision was made on September 15, 1893, about four inches in length between the old cicatrix and the median line. The adhesions posterior to the liver were so firm that the intention of examining the common duct and removing any obstruction that might be located there had to be abandoned and cholecystenterostomy was performed in the hope that a new free channel between the gall-bladder and the intestine would not only cure the biliary fistula, but relieve her of her pains. The duodenum was so firmly bound down by adhesions, that it could not be brought up; a loop of the jejunum was therefore picked up, the gall-bladder opened near its abdominal attachment, and attached to the jejunum by means of the "Murphy Button" in the usual way. The abdominal wound was closed by silk-worm-gut sutures, and a piece of iodoform gauze was packed into the old biliary fistula. The patient rallied well from the operation; two hours afterward her pulse was 76 and temperature $100\frac{2}{5}°$.

The first two days after operation, a large quantity of bile was discharged through the fistulous opening, and on the third day she showed some signs of jaundice.

September 23, there was some blood mingled with the bile discharged; the skin surrounding the fistula had become slightly eczematous. In the evening of the same day, when the dressing was changed, there was only a very little blood contained in the bile discharged, but it had a distinctly fecal odor.

September 26, the discharge does not contain so much bile as formerly, but seems to consist of mucous and fecal matter tinged yellow by bile. Eczema of skin still very annoying. For fully a week there was quite a copious discharge of mucous and fecal matter, so that the dressings required changing three or four times a day. No rise of temperature since September 23.

October 11. Patient sat up nearly the whole afternoon; during this time the button was passed by the bowels, just twenty-seven days after operation.

October 20. Dressing showed no evidence of discharge for two days; eczema all disappeared; laparotomy wound completely healed; patient is able to be up all day and feels quite well.

Since her discharge from the hospital she has been able to return to her work as a servant girl, and has been in very good health until about three or four weeks ago she fell down a flight of stairs, alighting on her right side over the old cicatrices, which gave rise to considerable pain over the region of the gall-bladder.

In a similar case of biliary fistula, it would be preferable to separate the adhesions between the gall-bladder and the abdominal wall, and place the male portion of the Murphy Button into this old fistulous opening, and unite that with the intestine. This has the advantage that no new opening is required in the gall-bladder, and that the fistulous

tract in the skin can be closed at once, doing away with all biliary and fecal discharges with which the convalescence of this case was complicated. The fact that the gall-bladder remains attached to the abdominal wall after anastomosis is made, interferes with its contraction and favors the continuance of the fistula.

MUSCULAR ASTHENOPIA AND ITS TREATMENT BY GRADUATED TENOTOMY.

Read Before The Medical Society of the State of Pennsylvania.

By Chas. Hermon Thomas, M. D.,
Philadelphia.

During the past decade, a great advance has taken place in our knowledge of the anomalies of the ocular muscles. Until well within that time, the standard text-books on ophthalmology, so far as I am aware, recognized the so-called insufficiency of the internal recti only, as the cause of muscular asthenopia; affections of the remaining muscles being treated solely in their relations to diplopia and strabismus. It is now almost universally conceded that the opposing and vertical muscles are subject to like defects, with corresponding symptoms of equal or even greater importance. Recent editions of systematic treatises show that most writers now give to the whole range of muscular anomalies the prominence which their importance demands. Among these may be mentioned the latest edition, the work of Noyes, which treats the subject elaborately, and also the works of de Schweinitz and of Norris and Oliver, both of which latter deal with it at considerable length. The increased interest and scope which the subject has acquired has resulted in the very general adoption of a new and systematic nomenclature—that originally proposed by Stevens. This improved terminology is employed by the authorities just named and is also introduced in the recent American editions of the works of Fuchs and Juler. As showing the increased importance accorded to the subject, it is worthy to be mentioned that at the meeting of the Pan-American Medical Congress, held in Washington within the past year, one day out of four was allotted by the Ophthalmic Section to the discussion of disorders of the ocular muscles.

The form of asthenopia under consideration results from disturbance in the normal use of the eyes as a pair—in effect acting as one single and not two separate organs—*œil cyclopienne*. The uncontrollable impulse to secure binocular vision throws upon the extrinsic muscles of the eye a constant and delicate service during the continuous effort to maintain accurate adjustment in the fixation of objects viewed. Interference with the movements of the eyes by disturbance of the normal relations of their muscular components calls for an excessive expenditure of nervo-muscular energy, to secure compensation and maintain the eyes in the proper position to secure single binocular vision. Exophoria—divergence defect—may demand the utmost exercise of the power of convergence, constantly applied; esophoria—convergence defect—on the contrary, that of an excess of abduction, involving the development of an unusual and abnormal innervation and muscular action. Such efforts may prove exhausting and are frequently the cause of disturbances which manifest themselves in a series of symptoms more or less marked and important.

The symptoms most frequently observed are, a sense of fatigue in the eyes, more or less constant and usually aggravated by definite use; objects viewed become indistinct and sometimes double, with occasional transient strabismus; headache; photophobia; dizziness; great discomfort while looking at moving objects, and when the patient is himself in rapid motion, as in looking out of a moving railway train; pain in using the eyes for definite fixation, which pain is fre-

quently referred not to the eyes alone, but to the frontal, temporal or occipital regions, rarely to the vertex. Indeed, a large proportion of cases of headache, whatever the special variety, are symptomatic of eye-strain due to ocular defects and, many of them, to disturbances of the ocular muscles. Headache may supervene at once upon use of the eyes or it may be delayed.

The following conditions, alone or variously combined, are frequently present:—pain in the back; drowsiness in some, insomnia in others; a variety of reflex neuroses; mild blepherospasm, involving a few fibres only of the orbicularis; twitching of the eye-lids; palpitation of the heart; night terrors; nausea; indigestion; constipation and a host of other symptoms.

These symptoms and such as these, however, it will be seen, are often associated with accommodative asthenopia as well; excepting only the transient diplopia or strabismus mentioned, and which is of infrequent occurrence.

On the whole, it may be said that the subjective symptoms of asthenopia as elicited in the consulting room, show almost no distinctive characteristics pointing to their especial origin, whether refractive or muscular; the same headaches and the same sense of eye-strain are complained of under both conditions. The test which has been given as differentiating the two disorders, namely, the use of one eye, the other being excluded from the act of vision for a time by covering it, has, in my experience, usually proven inefficacious.

Practically then, though the subjective symptoms alone are often inadequate to show the existence of muscular defect, objective investigation usually yields definite and uniform results, often indeed showing an exactness scarcely inferior to those obtainable in refractive determinations. Sometimes, but very rarely, the conditions found are inconstant or even erratic, and then great care is required in the estimation of their value.

As regards objective tests, the so-called cover test is the most readily applicable and is deserving of much confidence; it should not be omitted in any case. The diplopia tests such as vertical prisms, Maddox rod, etc., and the determination of abduction, adduction and sursumduction are indispensable in reaching a reliable conclusion.

It should be a fixed rule of practice to eliminate first the refractive and accommodative elements in any case under examination, by the proper glasses, leaving the muscular conditions to be dealt with at the last. Under these circumstances, it will be found occasionally, though not as frequently as could be wished, that the muscular anomalies vanish after correction of errors of refraction accommodation; the final test as to which of these may be the active disturbing agent in any particular case, must frequently be the therapeutic test.

The following cases selected from my case books are presented as illustrative of the clinical history, treatment and its results in patients, the subjects of disorders of the ocular muscles:—

I.—T. H. L., mechanical engineer, aged 42, referred to me by Dr. W. H. H. Githens, June, 1891. Wearing high hyperopic correction combined with prism before each eye, 4 degrees, base in. Divergent squint, right eye deviating, except when attention is fixed. Diplopia except on great and tiresome effort, notwithstanding the prisms worn; much headache, confined mostly to the region of the brow. Reading and other definite and constant use of the eyes always at the expense of fatigue, which is only partially relieved by covering one eye; a page of ordinary size often overlaps one-half. Is particularly disturbed by sounds which are slight and not ordinarily noticed. Has multiple false images, monocular. Exophoria 14°. Operation, right externus, complete section, immediate result, orthophoria. Two weeks later, exophoria 8°, operation, complete, retrenched with suture, result, orthophoria. One month later, exophoria of 3°, reasserted. Exophoria in accommodation 20°.

Expresses much satisfaction in the comfort derived from the operation. Has no tendency to diplopia for distant, but somewhat for near vision. Has a new sense of solidity in objects viewed; is

conscious of definite binocular vision. There is also relief of the headache and of the abnormal sensitiveness to sounds. Finds that the use of eyes, as in accurate examinations of instruments and drawings, is now possible where it was not before. The false images, monocular, noted at the first visit, have almost entirely vanished.

Three years later there is an exophoria of 2°, exophoria accommodation 26°, and an Ab. of 4°, and an Add. of 11°. Has passed the intervening time since the operation in occupations involving much use of the eyes, but in entire comfort.

II.—H. R. S., aged 48, master builder. A man of great physical strength and endurance; suffers severe pain localized in the eyes; complains particularly of the right eye feeling as "if it were drawn out by a cork-screw." This is accompanied by general nervousness and irritability with a prickling sensation over the whole body, after reading for a comparatively short time. Eyes feel dry and uncomfortable. All discomforts vanish to a great degree when away on vacation and the eyes are resting, except a severe headache which has been habitual and almost constant for years. Has high hyperopia, R 5, D. L 4, D.

Convergence defect: Es. 5°. Tenotomy right internus, result, orthophoria. Four months later reported no headache since the operation and that relief occurred within 24 hours. All the symptoms before described have vanished. Patient highly appreciative of the change for the better which has taken place.

III.—H. W. P., retired merchant, aged 64; makes no complaint of pain or sense of strain, but only of some annoyance or inconvenience in the use of his eyes. He has a hyperopia of 1 D, which corrected, gives him full vision in both eyes. He is able to fix distant and near objects with both eyes and at no time is there any manifest strabismus. He has a habit of opening and closing his eyes alternately every few seconds, during which act he elevates and corrugates the brow of the open eye excessively. This he does both in reading and in conversation, producing a very grotesque appearance, and, which being much remarked by his friends is, perhaps, the principal reason why he seeks advice.

A muscular test shows a divergence error, exphoria 20°, with a left hyperphoria of 2°. After wearing correcting prisms for a few days, the Ex. increased to 25° and the Hy. vanished. An operation was then performed, a complete section of the right externus, resulting in a reduction of the Ex. to 13°; and two days later a tenotomy was made on the right externus, not entirely complete, leaving an Ex. of 6°. Six months later there remained an Ex. of 5°. The habit of opening and closing his eyes alternately which was plainly an instinctive movement to avoid diplopia, had ceased with the operation and he expressed himself as entirely comfortable. His appearance is greatly improved. The small amount of exophoria remaining I deemed it conservative, under the circumstances, to leave uncorrected.

IV.—R. P. B., referred to me by Dr. Stubbs of Wilmington. Suffers from intense nervousness, extreme insomnia with mental depression, accompanied by suicidal fears. Close application to her work (that of painting fine decorations on silk) causes distress of a grave character in the forehead near the eyes, sometimes running down the nose and extending to the face. Has had headache only recently. Uncontrollable winking at times, very troublesome, frowns habitually. Eyes not pained by use. Prickling sensation over the whole body, at all times, but mostly at night. Refraction normal, Es. 1°, Hy. 1°. Prescribed vertical prism correcting hyperphoria, which gave immediate relief, frowning ceased. Much irregularity of reaction of vertical and lateral muscles, but Es. of 10° proving very constant, tenotomy of right internus was performed. Great improvement and abolition of all symptoms followed immediately. Three months later, orthophoria was established. Insomnia and nervous symptoms entirely abolished. Patient describing her condition said she was now entirely comfortable.

V.—W. J. D., aged 35, book-keeper, referred to me by Dr. E. J. Nolan. Has high compound hyperopic astigmatism, for which he wears the correcting glasses, but complains of pain around the eyes with dull pains in the occiput. Symptoms aggravated by use of eyes for near work, interfering with regular duties. Has manifest Es. 12°–15°. Ordered prisms aggregating 10°, base out, which were worn for a week with comfort. Es. advanced meantime to 22°. Tenotomy, right internus, complete section, result, Es. 4°. A week later after 12° was manifested with marked recovery from convergence under cover test. A second operation, left internus, section almost complete; result, orthophoria when his sphero-cylinders are worn, though there is recovery from convergence, Es. 6°, when glasses are removed. Reports entire comfort and ability to use his eyes to an unlimited amount.

Considerable discussion has taken place as to the relative frequency of esophoria and exophoria and different writers have asserted a marked preponderence on either side. A review of my cases for the last nine years shows that in the operative cases, as between esophoria and exophoria, these are almost exactly equally divided; and while there has been a certain variation on one side or the other from year to year, a close parallelism has been maintained in the main throughout the whole period. This examination also shows, as regards the refraction in both these forms of heterophoria, that hypermetropia predominated. The predominance of hypermetropia was more marked in the cases of esophoria than in those of exophoria, as the following figures show:

In esophoria the relative frequency of H. over M. was in the proportion of $3\frac{3}{4}$ to 1; in exophoria the relation of H. to M. was as $2\frac{1}{2}$ to 1. Thus, while the most of the cases of heterophoria show hyperopic refraction—as is to be expected considering the greater frequency of this condition over myopia; when the static refraction is viewed in its relation to the accompanying heterophoria, we find that hypermetropia is usually accompanied by esophoria and myopia is most frequently associated with exophoria.

There is still to be found occasionally one who maintains the opinion that a complete tenotomy is required in every case of heterophoria calling for operation, on the assumption that no gain whatever is to be derived from partial severance of the tendon. My experience leads me to a directly opposite conclusion.

In my first paper on this subject, written six years ago,* I stated in effect that the fan-shaped expansions of the tendons of the recti at their insertion into the sclerotic are wider and thinner and their margins more elastic than is generally appreciated; and, that the elasticity of the margins is an influential factor in the production of a relaxation of tension in the tendon, graduated and definite in amount and permanent in character, permitting the effectual central portions of the tendon to retract and form a new attachment to the globe further back. This I desire at this time especially to reaffirm and to add that graduated tenotomy is practicable and effective, only because of the elasticity of the margins of the tendons. No attempt is here made to distinguish between the tendon and its immediate covering derived from Tenon's capsule; for distinct as they are anatomically, they are one surgically, for the purposes of this operation, at least, and are to be treated as one.

It is true that occasionally a case is found in which no appreciable change in position occurs until complete severance has been accomplished, but such cases are altogether rare and exceptional. *In the great majority of cases a gain graduated from 1° to 8° may be made without complete severance.* In those exceptional cases referred to, the tendon is thick and narrow at its insertion, and the elastic margins are either deficient or absent.

The technique of graduated tenotomy involves considerable difficulty and complication at times, and the performance

*Graduated Tenotomy in the Treatment of Insufficiencies of the Ocular Muscles, by C. H. Thomas, M. D. *Trans. Philadelphia County Medical Society*, March, 1888.

of the operation is not to be looked upon as in any sense a trivial procedure. It is an altogether more delicate and difficult operation than that for strabismus ; and not less so indeed than any other operation done upon the eye-ball, not excepting that for cataract ; but when skillfully performed, it may be expected to yield definite and satisfactory results. It cannot be successfully undertaken without special instruments. Those devised by Dr. Stevens leave little to be desired. The ordinary strabismus instruments are altogether unsuitable by reason of their coarseness and clumsiness and should never be employed.

A study of nearly ten years faithfully pursued in all cases of asthenopia coming under my care has lead me to the following conclusions :

Muscular asthenopia may present symptoms of all grades of importance, from the slightest to the most serious.

The muscular conditions in every case should, as a matter of routine, be as carefully investigated as are the media, eye-ground, refraction and amplitude of accommodation.

As in refractive, so in muscular asthenopia, the gravity of the symptoms bears no constant relation to the amount of the physical defect. It is impossible to predict with any considerable degree of definiteness the result of correction of either refractive or muscular error. As much and very much the same kind of relief is to be expected from the correction of the muscular anomalies as from the correction of errors of refraction and accommodation, as might be expected from the similarity in the symptoms which these conditions respectively cause.

During the earlier years of my study of these cases, I gave considerable attention to the graver neuroses—especially epilepsy—in connection with muscular anomalies ; continuing the observation of a series of epileptic cases throughout a period of about five years. The results obtained in this series were altogether negative, not one recovering. With expectations of cure of epilepsy greatly abated, I nevertheless consider it proper to remove eye-strain of muscular origin in this affection as I would in any other condition ; and for the additional sufficient reason that sound conservatism in the management of epilepsy calls for the removal of all possible sources of peripheral irritation.

Extirpation of the Uterus in Disease of the Adnexa.—Dr. J. M. Baldy asks in the *American Journal of Obstetrics* the following questions in connection with extirpation of the uterus in disease of the adnexa:

Is the uterus essential or useful after the ovaries have been removed ? If not,

1. Are all patients cured after an operation requiring double ovariotomy ?

2. Are patients cured after hysterectomy, when double ovariotomy has failed ?

Having settled all these questions in the affirmative, he says that in America, with rare exceptions, the abdominal method of extirpation has been the one preferred for the reasons :

1. That all the parts may be exposed to the eye as well as to the touch, and hence greater accuracy and security obtained.

2. The adnexa may be completely removed together with the womb (a very great desideratum).

3. All intestinal injuries may be readily discovered and corrected.

4. All wounds may be closed, denuded surfaces often covered over with peritoneum, and in many cases drainage avoided. American operators have kept the mortality by this method as low or even lower than the French surgeons have by the vaginal method, with the additional advantage of making a complete removal of diseased structures, and are therefore more secure in the chances of better results. The only possible condition in which vaginal hysterectomy may be preferable is in those cases where there is large pelvic abscess accompanied with dense and extensive intestinal adhesions which it would be impossible or highly dangerous to the intestines to separate.

CORRESPONDENCE.

CUMBERLAND, MD.,
Aug. 18, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—The physicians of this city are taking a deep interest in the new medical law passed at our last General Assembly. There are some willful violators in Alleghany county who persist in their refusal to comply with the law. The members of the State Board, Drs. W. W. Wiley and C. H. Brace, have determined to prosecute these men to the full extent of the law. At a meeting of the Association of Physicians and Surgeons of Cumberland, the following resolutions were passed:

WHEREAS, The Legislature of the State of Maryland at its last session passed a wholesome law regulating the practice of medicine in the State, and,

WHEREAS, We being law-abiding citizens who have complied cheerfully with its provisions, believing that a strict application of them will be beneficial, do hereby

Resolve, That Dr. W. W. Wiley and Dr. C. H. Brace, members of their respective boards of examiners, be urged to take prompt action in bringing all violators of the law to trial, and see that the law does not become a dead letter in the future.

It is certainly a gross injustice to permit some who have graduated since 1892 to practice without appearing for examination, and require others to do so. And yet the officers are hampered in their efforts to put the law into execution by the cry from the people of jealousy of the offenders. It seems well-nigh impossible to impress upon the laity the fact that medical laws are passed as much for their benefit as for the profession; that if the profession is protected from the inroads of quacks and charlatans, they themselves enjoy the same immunity. If this law which has been recently enacted is a good one, and it certainly seems to be, every good citizen as well as physician should be interested in its enforcement. Other States have these restrictive laws and after trial have found them beneficial in every way, elevating the standard of the profession, protecting the public from ignorant and dangerous quacks, and giving to the profession of medicine the importance due it by right of the good it accomplishes for the general public. It behooves us as physicians of Maryland interested in the welfare of our profession and the people of our State to see this medical law rigidly and fairly enforced.

E. T. DUKE, M. D.

MEDICAL PROGRESS.

IMMEDIATE REPAIR TO INJURIES OF THE PELVIC FLOOR.—Dr. George M. Boyd reports in the *New York Journal of Obstetrics and Gynecology* 721 cases of completed labor with 117 injuries of the pelvic floor, and in some of these cases fearing rupture in the perineum or elsewhere he has been ready to operate and in most of these cases he operated at once. His conclusions from these cases are:

1. As every obstetrical case is greatly a mathematical problem, so is the safety of the pelvic floor; if the passenger is too large for the passageway (something must give), a tear, either vaginal or perineal, will follow.

2. As it is our duty to study all obstetrical cases before labor by palpation and pelvimetry, just as much is it our duty to examine the perineum and vagina after labor.

3. That having any injury to the pelvic floor, it should be at once repaired, and a good method to follow is to perform the operation under constant irrigation, using sterilized Chinese silk for sutures, and avoiding infection of wound by placing the stitches without inserting the finger in the rectum.

* * *

ATONY OF THE INTESTINE.—Atony of the intestine, which is one of the principal causes of constipation, receives a very full consideration at the hands of Dr. Julius Friedenwald in the *Medical News*. The treatment of this condition may be difficult, but it is certainly simple and Dr. Friedenwald gives it as follows:

The treatment of intestinal atony depends upon its cause. If the condition is secondary, the treatment must be directed to the primary disorder.

Chronic constipation is the symptom that occasions most annoyance, and special attention must be directed to it. In all uncomplicated cases of atony of the colon the condition can be successfully relieved by simple measures. The hygienic and dietetic treatment is highly important. Inasmuch as sedentary habits predispose to this disorder, exercise is of some value in many cases. This should consist in walking, as well as in gymnastics in which movements of the trunk play a prominent part.

Such foods are ordered as stimulate intestinal peristalsis. In this class are included substances that furnish a large quantity of undigested residue, such as fruits, vegetables, salads, Graham and rye breads. When there is no special contra-indication (such as gastric atony), large quantities of cold water taken before breakfast may be serviceable.

There are certain natural mineral waters which are sometimes of great value in the treatment of intestinal atony unaccompanied by atony of the stomach; the Glauber salt waters belong to this class. The waters of Marienbad are considered of great value for this purpose, especially in the obese; but the saline waters, Kissingen Rokoczy, are sometimes preferable. However, as many cases of intestinal atony are accompanied by atony of the stomach, the use of large quantities of water in these cases should be very restricted.

Persons suffering with intestinal atony should avoid the use of food that tends to constipate. In this class may be especially mentioned red wines, tea, and rice.

The systematic employment of abdominal massage is of great value. There are but few uncomplicated cases of intestinal atony in which the constipation does not yield to this form of treatment. In very persistent cases the manipulation must be practiced daily, or on alternate days at least, for from eight to twelve weeks. To be effectual the movements must be deep.

Abdominal massage is much assisted by electricity; by the external application of moderately strong faradic currents good effects are usually obtained; or the faradic current may at times be applied internally, one electrode being placed in the rectum, the other on the abdomen. When the galvanic current is used the rectum is filled with water before the negative pole is introduced, the positive pole being placed upon the abdomen.

In cases in which massage and electricity cannot be employed excellent results are frequently obtained by injections of large quantities of oil, as recommended by Fleiner. When the conditions insisted on by Fleiner are fulfilled the injections rarely fail. In a large number of cases in which I have employed these injections for the treatment of this form of chronic constipation they rarely proved unsuccessful. The regulations to be fulfilled are: 1. Only the very purest oil should be employed; olive oil is the best. 2. Large quantities of the oil (from ten to fifteen ounces), heated to the temperature of the body, must be injected while the patient is resting on the back with the pelvis raised. 3. The injections must be given carefully and slowly, so that no air enters the colon. When air is introduced severe colicky pains are frequently produced and the oil is immediately ejected. 4. The oil must be retained in the bowels for several hours; for this reason it is best for the patient to remain in the reclining position for several hours after the injection has been given.

When the injections of oil and the other methods just mentioned cannot be employed, injections of other fluids, such as warm water, cold water, glycerine, may prove serviceable. The introduction of glycerine suppositories into the rectum or the application of powdered boric acid to the mucous membrane of the rectum sometimes gives relief.

The employment of cathartics is in most cases to be deprecated. Inasmuch as patients become quickly habituated to remedies of this kind and their effect

gradually wears away, larger and larger doses become necessary. When cathartics must be given the simplest are the best, and the various preparations of cascara sagrada seem to me to head this list. Pills of strychnine sulphate or the extract of nux vomica with belladonna are to be highly recommended to strengthen the relaxed condition of the bowels.

* * *

CEREBRAL EDEMA.—Dr. George J. Preston draws the following conclusions in his paper on cerebral edema, in the *Journal of Nervous and Mental Diseases:*

1. Cerebral anemia should receive recognition, both from the clinical and pathological standpoint.

2. Edema of the brain follows the law of edema elsewhere in the body, with the important exception that these laws must of necessity be considerably modified by the anatomical arrangement of the lymph spaces of the brain and its membranes.

3. The effused serum may exert injurious mechanical pressure, and also offers occasion for toxic influences.

4. Cerebral edema would be a much more common and serious affection were it not for the communication which exists between the various lymph spaces, as emphasized by the decided symptoms produced when these cavities are isolated by inflammatory adhesions.

* * *

LOCAL ANESTHESIA WITH COCAINE.—Dr. W. P. Carr of Washington, D. C., contributes an article to the *Virginia Medical Monthly* on local anesthesia with rules for the hypodermic use of cocaine. The three local anesthetics are carbolic acid, cold and cocaine. In referring to the latter drug he has used it on himself and with all due respect to failures in its use as reported by other physicians, he thinks no complaint as to the results will be made if the following rules be observed :

1. Keep the syringe in good working order, clean and aseptic. Use a small sharp needle and boiled water.

2. Use a four to eight per cent. solution.

3. Disinfect the part with a sublimate solution one to one thousand, or one to five hundred, before using.

4. In making the first injection choose the least sensitive spot central to the site of operation and near the nerves leading to it. This may be an inch or even two inches distant. Inject, at first, only a third or a fourth of the quantity you expect to give.

5. If possible put a rubber ligature around the part above your injection. Make this ligature just tight enough to stop the circulation and prevent bleeding while you are operating. It need not be tight enough to cause much discomfort. This prevents constitutional symptoms and prolongs the local effects.

6. Wait until you get the effect of the first injection, which may be five minutes, or even ten or twelve minutes if it was placed deeply. Then make all subsequent injections by passing the needle through the skin where it has lost sensation and running it along under the skin in the direction indicated.

7. Before beginning to operate, pass the needle all around and beneath the field of operation, to see if all parts have been thoroughly anesthetized. If not, inject a little more at the sensitive spots.

8. If sutures are needed, place them before removing the rubber band ; but do not tie them until the band is removed and the bleeding checked. Sensibility soon returns after removing the ligature.

9. If a large dose has been used, and constitutional effects are feared, put the ligature back after the operation, and leave it for an hour or so.

* * *

KISSING AS A SANITARY SIN.—Johannes Secundus in his *Basia* might be thought to have dealt with kissing from every conceivable point of view, but he lived in prehygienic days, says the *British Medical Journal*, before the fear of the ubiquitous bacillus had eclipsed the gaiety of nations. Preachers of asceticism used to condemn kissing on the ground of its danger to the soul, but to the "average sensual man" the added spice of sin probably made it all more delightful. Now the apostle of sanitary

perfection is denouncing kissing for its dangers to the body. The Japanese, he tells us, are a hygienically-minded people, and they never kiss. The Sanitary Committee of the Orange (New Jersey) Board of Health has recommended that a circular be sent out to all whom it may concern "urging everyone to desist as much as possible from kissing, as the touching of lips is likely to convey contagion." That foul and deadly disease may be, and often is, propagated in this way is of course a fact as to which there can be no sort of doubt. Many a mother has, like the Princess Alice, caught infection from the lips of her child dying or dead of diphtheria. There is every reason to believe that the seeds of tuberculosis may be implanted by kissing, and the too common beslobbering of children by friends of the family and by effusive strangers cannot be too strongly condemned on hygienic grounds. It cannot therefore be denied that kissing is dangerous, but will "sanitary committees" be able to put it down, as a too sanguine magistrate once undertook to "put down" suicide? Will love-making be conducted on antiseptic principles? "Kissing goes by favor" we are told—is it for the future to be by favor of the county council? Great no doubt is Hygeia, but we will back human nature with some confidence against her.

* * *

Thyroid Theory in Graves' Disease.—Dr. J. Arthur Booth gives a brief review in the *Journal of Nervous and Mental Diseases* of the thyroid theory of disease, and reports two cases of thyroidectomy, from which he concludes that:

1. It is by no means decided that a mere excess of the thyroid secretion is the sole and essential factor in Graves' disease; but as microscopical examination has demonstrated an enormous hyperplasia of the secreting structure, it is certainly reasonable to suppose that these changes must have some profound effect, both on the quality and quantity of the secretion.

2. If altered structure and not size is the test of the disease, then thyroidectomy should be considered even in those cases where there is little or no enlargement of the thyroid.

3. Cases of Graves' disease may be entirely cured by thyroidectomy.

How this is brought about is not clear as yet. It may be in one of three ways, viz.: a diminution of the functional activity of the gland substance; a relief of the stretching and irritation of the sympathetic nerve fibres; or, finally, in the removal of pressure.

* * *

Electricity in Diagnosis and Prognosis.—Dr. William M. Leszynsky reports to the New York *Medical Record* an article on the value of electricity in the diagnosis and prognosis of disease of the isolated peripheral nerves, and after relating a number of cases draws the following conclusions, which he hopes will controvert a number of popular fallacies:

1. That the value of electricity as an accessory method in diagnosis and prognosis of disease of the peripheral nerves is not as universally recognized as its importance demands.

2. That the result of this procedure often furnishes corroborative and conclusive evidence where only a provisional diagnosis has been made.

3. That the necessary technical skill in successfully pursuing such investigation and correctly interpreting the result can only be acquired through special study and practice.

4. That the use of the faradic current alone is quite sufficient for diagnostic purposes.

5. That, as a rule, the galvanic current is supplemental to that of faradism, and in the absence of faradic irritability in nerve and muscle it is of the greatest service in prognosis.

6. That the discovery of the reaction of degeneration is not an essential feature in the differential diagnosis as to the location of the lesion.

7. That the peripheral nerve-fibres possess an inherent power of regeneration, which seems almost unlimited, the length of time required for the completion of the regenerative process varying from a few weeks to seven years or more. Therefore in severe forms of in-

jury the cause, degree, and character of the damage to the nerve are often of greater importance in prognosis than the demonstration of the reaction of degeneration.

8. That the presence of R. D. or partial R. D. is not incompatible with the preservation of motility in the same area. This paradoxical condition has been found in cases of lead-poisoning, and a few others, but thus far the cause has been inexplicable.

9. That strong currents are only rarely necessary. The weakest current that will produce a distinctly perceptible reaction is all that is requisite.

10. That a decrease or disappearance of faradic irritability in nerve and muscle simply denotes an interference with the nutrition in the course of the motor tract between the multipolar cells in the anterior horn and the peripheral nerve distribution. It does not enable us to judge of the nature of the pathological process.

11. That the character of the reactions does not differ whether the lesion be situated in the cells of the anterior horn, the anterior nerve-roots, the nerve-trunks, or in their ultimate distribution. The same rule holds good in reference to the various cranial motor nerves and their nuclei, such as the facial, hypoglossal, and spinal accessory nerves.

12. When the farado-muscular irritability is lost no reaction can be obtained by a rapidly interrupted galvanic current.

13. The secondary current from an induction coil is the one generally used in testing faradic irritability. Owing to its high electro-motive force the resistance encountered in the moistened skin may be considered negligible.

14. The difference in the poles of the faradic current is only a relative one, and cannot be determined by the usual tests as applied to the galvanic current. The electro-motive force in the secondary coil is greater at the "break" than at the "make." The electrode that is felt to be the stronger in its action is usually considered as the negative, or so-called "faradic cathode."

15. In some apparently healthy individuals the musculo-spiral nerve fails to react to strong currents applied with the "faradic anode," while a comparatively weak current from the "faradic cathode" calls forth a quick response.

16. In a case of undoubted peripheral paralysis the faradic irritability may be preserved, but it almost invariably requires a stronger current to produce muscular contractions than upon the healthy side (quantitative decrease). [The writer has never seen a case where this could not be demonstrated within a few days after the onset of the paralysis.]

17. The character of the muscular reaction demands attention. A slow and labored contraction associated with decrease in faradic irritability denotes degenerative changes.

18. The faradic irritability may return in persistent cases of peripheral paralysis without any perceptible improvement in motility.

19. Electro-diagnosis is inapplicable in paralysis of the ocular muscles.

* * *

Chlorate of Sodium in Cancer of the Stomach.—Brissaud, says the *British Medical Journal*, was led by observing the effect of chlorate of potassium in epitheliomatous growths of the mucous membrane of the upper digestive tract to try the effect of chlorate of sodium, which is much more soluble, in cancer of the stomach. The results were so remarkable that Brissaud thinks it well to anticipate the suggestion of an erroneous diagnosis. In most of his cases, in addition to the classical symptoms, there was a well-defined tumor in the gastric region. After giving chlorate of sodium in daily doses of 12, 14 and 16 grammes for about six weeks, melena and hematemesis ceased entirely, cachexia disappeared, and the tumor could no longer be felt. Brissaud does not claim to be able to cure all cancers, but he affirms that there are certain forms which are curable by means of chlorate of sodium. Such are particularly those epitheliomata in which there is no extension of the disease to the liver or other parts, and no complication of the nature of thrombosis or phlebitis. Chlo-

rate of sodium is less poisonous than chlorate of potassium, and is readily eliminated. The daily dose is from 8 to 16 grammes (2 to 4 drachms). Brissaud begins by giving from 8 to 10 grammes in the twenty-four hours, and if the vomiting and hematemesis do not cease he increases the dose till these symptoms are controlled. He gives the drug mixed with 100 grammes of water in teaspoonfuls. The only contraindication is the presence of albuminuria, even to a slight extent. More than 16 grammes should never be given in the twenty-four hours for fear of bulbar accidents. Brissaud suggests that chlorate of sodium may also with advantage be substituded for chlorate of potassium in the treatment of stomatitis, etc.

* * *

Tubercle Bacilli in the Nasal Cavities of Healthy Men.—Strauss (*British Medical Journal*) describes some experiments made on patients and pupils connected with the Hospitals of La Charité and Laennec, with a view of proving that tubercle bacilli may lodge in the nasal cavities of persons presenting no suspicion of tuberculosis, and yet retain their virulence. Tampons of sterilized cotton wool were introduced into the nasal cavities of six healthy nurses living in the hospitals, of seven healthy pupils making daily visits, and of three inmates suffering from chronic non-tuberculous affections, and afterwards shaken up in sterilized bouillon or water. This liquid was then injected into the peritoneal cavity of twenty-nine guinea-pigs. In seven cases the animals died of septicemia or purulent peritonitis; in thirteen cases they remained apparently well and no definite lesion was discovered *post mortem;* in nine cases they died or being killed at the end of three to five weeks presented decided tuberculous lesions. Apparently, therefore, tubercle bacilli may enter the system through the nose, may while remaining in the nasal cavities fail to infect the individual, and yet may retain sufficient virulence to prove infectious when inoculated into guinea-pigs. Strauss's observations also throw some light on the fact that the subjects of repeated epistaxis not infrequently become tuberculous.

* * *

Bromoform in Whooping-Cough.—The latest treatment of whooping-cough is by bromoform. Dr. Herbert B. Carpenter describes it in the *Philadelphia Polyclinic*, and thinks it is almost a specific. Its good effect is due to its acting as a local anesthetic upon the mucous membrane of the pharynx and larynx. It seems to moderate the violence of the individual paroxysms, diminishing their severity and frequency, often stopping the vomiting in twenty-four hours, and in many cases it shortens the duration of the disease. Bromoform is given in one to five drop doses, three or four times daily. It may be given on sugar or in the following formula:

℞.—Bromoform . . . *m*xlviii
Alcohol . . . . ℥ss
Tinct. cardamon. Co. ℥iii
S.—Take a teaspoonful in water.

As bad effects are rarely seen from small doses, it should be kept up for some time.

* * *

Headache.—Dr. Daniel Clark contributes to the *Canadian Practitioner* an article on headache, in which his aim is: 1. To direct attention to the importance of studying the reflexes in our diagnosis. 2. In trusting more to general hygienic measures to promote health than to local or general medication. 3. To study *ab extra* causes which are more general and potent than we may suppose. We are often deceived because of the local distress appearing so prominent. 4. Not to delude ourselves into the idea that a benumbing treatment is curative, but, on the contrary, it often handicaps the heroic efforts of nature to again reach healthy conditions. 5. To check the growth of the ever-increasing army of narco-maniacs by professional reticence in the use of seductive drugs. Headache and its many anodynes are fruitful sources through which this baneful habit is acquired. 6. The treatment must be applied to *genera* rather than to the *species*, as common causes lying in deranged cell life do produce multifarious manifestations.

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See Publishers' Department, Page 376.

BALTIMORE, AUGUST 25, 1894.

Chemical Tests for Glucose.

The London *Lancet* has had of late various communications on some common sources of error in testing for sugar in the urine and the periodicity with which this subject of sugar testing is brought up shows how little reliance is placed in the ordinary tests and what various opinions are held.

From the careful chemist who can find sugar in every specimen submitted, to the ordinary physician who hastily adds a little Fehling's solution, heats and gives his opinion in a few minutes, there is a wide range; but it is forgotten that there are two sides to this question; and it is not whether there is a trace of glucose in normal urine, but is the glucose that is found in a given specimen sufficient in amount to render a grave prognosis, or important enough for the patient to receive active treatment. Some chemists, like some microscopists, can find anything they are looking for, if they only have the time, and, they usually wish to find the desired object; while the physician testing for sugar in a suspected case of glycosuria or diabetes is very anxious to have a normal specimen.

While theoretically it seems a very grave condition when sugar is present we know practically that it appears and disappears so often with no apparent good reason that its presence does not necessarily indicate diabetes. Indeed in cases of undoubted diabetes where the specific gravity is high and sugar is passing away in no small quantities, the patient often thrives and seems as well as anyone except for the anxiety caused by the sugar.

But to return to the errors in testing for sugar, it seems very strange that notwithstanding delicate tests have been pointed out and these errors in using the copper test are so often noted, yet most if not all of the prominent life insurance companies still cling to these copper tests and require nothing further. There is no doubt that all sugar tests are unreliable and even with the microscopic demonstration of the sugar crystals in the phenylhydrazin test, there is not one which the chemist and physician unite on as being thoroughly reliable and trustworthy.

* * *

Why not Write?

JUDGING from accounts in the *British Medical Journal*, the recent meeting of the British Medical Association at Bristol does not appear to have been a very remarkable gathering. The usual addresses were given but in most cases they were on trite and well-thrashed subjects.

Still, even these subjects were well treated and it shows that the Englishman is very ready with contributions to medical literature even if nothing new is said.

In this place it may be noted that this may serve as a fitting example to physicians in the State of Maryland, who, although not lacking in skill and ability, are very backward in giving the results of their work to the public. When the men with large practices and holding many offices have time to contribute regularly to medical journals, it does seem rather strange that so many others with not one-tenth the work so often give the excuse of lack of time, or unwillingness to write until they have something new to say. With this misguided ambition they remain unknown forever.

It is not always by narrating new operations

and rare cases that the readers of medical journals are instructed, and perhaps entertained, but more by the relation of individual experience in dealing with the more common diseases that the general practitioner, who relies in part on journals for help, is lifted out of some difficulty and enlightened.

* * *

Union Medical Association.

It is announced that the seventeenth annual reunion of the Pennsylvania and Maryland Union Medical Association will be held at Columbia, Pa., on Thursday, August 30, 1894. This may be called one of the few honest medical societies, which meets for pleasure and amusement one day in each year and faithfully sticks to its programme. It is composed of members from the borders of Maryland and Pennsylvania who come together each August and have little to say and much to eat. Dinner is served at noon, then follows an address by the President of the Association, Dr. Levi Frey of York, and last of all comes the election of officers. The unique features of this medical association are, almost entire absence of medical work and the devotion of the time to pleasure and amusement. Members of the medical profession are always heartily welcome at this meeting and the Secretary, Dr. Craig of Columbia, is always ready to give information about tickets and means of transportation.

* * *

Off-hand Advice.

Parlor advice is unsatisfactory to all concerned. The physician may be paying a social visit or about leaving a patient when some person casually asks what is good for this or that ailment, or demands advice as to what will prevent this or that disorder and expects a categorical answer. Happy is he who can answer such a question without hurting his reputation. If medicine were such a simple science and remedies could be suggested with such little effort in course of a social visit or in passing, then the healing art could be reduced to a catechism with questions and answers so arranged in a large book that every one could find the proper answer, and the practice of medicine, which requires so much skill and judgment, would cease. But as long as no two persons are alike and the human frame is not put together on the plan of a watch or sewing machine, so long will physicians be unable to tell in passing what will cure or prevent an ailment that has been going on for months or years. It is hard to teach the laity the gravity of such questions and the conclusion of the whole matter in the mind of the thoughtless is that physicians know little more of such subjects than others and that the practice of medicine is a failure.

* * *

Anti-Cholera Inoculations.

The recent reports, if true, of Haffkine's success with anti-cholera inoculations would seem to show that in the use of the anti-toxines we have very powerful and efficacious remedies. Just how generally such preventive measures can be carried out is not easy to see. It would hardly be wise to let such dangerous remedies get into general use, especially as quacks and pretenders are so ready to take the slightest hint from genuine methods and foist false and perhaps harmful substances on a public that is always ready to be deceived. If preventive inoculations become a success, they should be used only in public institutions and hospitals where their genuineness may be assured.

* * *

Infantile Summer Disorders.

Infants bear with great difficulty a long spell of warm weather and are liable to attacks of diarrhea whether reared on breast milk or on the bottle. There is one great help, however, in taking an infant through this trying season and that is regularity in feeding. If the child be given the breast or bottle regularly and the intervals be so timed that digestion may be almost if not quite complete, while the amounts are carefully measured, there is much greater chance of avoiding summer troubles. Many cases of summer infantile disease occur because the infant every time it cries is given the bottle or breast. Attention to apparently petty details will often prevent serious troubles.

* * *

Complaints made by vessels bound for Baltimore of discourteous treatment at upper quarantine do not seem to be without foundation. Quarantine physicians who have a certain amount of authority in their hands should not bring discredit on this excellent system of protection to the city and country against disease by detaining unnecessarily long vessels and their owners to whom every hour may mean the loss of much money.

MEDICAL ITEMS.

Dr. Arthur D. Mansfield has been quite ill at his home on South Broadway.

The physician who treated the Czar last winter received a fee of $30,000.

The war between Japan and China has advanced the price of opium one-third.

Paris has 2208 medical practitioners, New York has 2580, not counting homœopaths.

Dr. J. J. Chisolm attended the meetings of the British Medical Association at Bristol.

Dr. William Frazier, a well-known oculist of Staunton, Virginia, died in that city last Monday.

Dr. Robert Reuling is practicing with his father, Dr. George Reuling, at 103 West Monument Street.

Dr. William J. Little died last month at London in his eighty-fourth year. He was the pioneer in orthopedics.

The Emperor of Austria has granted to the widow of the late Professor Billroth a yearly pension of 2000 florins ($1000.)

Dr. D. Clinton Morgan, near Calverton, has been critically ill, but is somewhat improved. Hopes are entertained of his recovery.

Dr. Judson B. Andrews, Superintendent of the Buffalo State Hospital for the Insane, died in Buffalo recently in his sixtieth year.

Dr. Arthur B. Reynolds, Commissioner of Health of Chicago, was in Baltimore last Monday to inquire about hospitals for infectious diseases.

The Supreme Court of Pennsylvania has decided that school boards have the right to exclude from public schools children who have not been vaccinated.

The honorary degree of Doctor of Medicine was conferred on Mr. Victor Horsley by the University of Halle on the occasion of the bi-centenary of its foundation.

The new tariff bill lowers the duty on many drugs in common use. Children will hardly rejoice to hear that the duty on castor oil has been reduced fifty-six per cent.

The Medical Officer of Health to the City of London receives a salary of $7500, and an additional sum of $1000 as analyst ; but he is obliged to give his whole time to the duties of the office.

The death is reported of Dr. James Kitchen, the oldest practicing physician in Philadelphia. Dr. Kitchen was born in 1800 and was a graduate of the University of Pennsylvania.

In order that the proceedings of the next International Medical Congress may be given to the public more fully and generally, there has been formed an International Medical Press Committee to provide greater facilities for this purpose.

Germany, with the usual enterprise in matters of this kind, proposes to erect sterilization stations at convenient points in the various cities and towns where physicians who have just left a dangerous case may be sterilized. The operation will take about fifteen minutes.

Dr. George A. Fleming of Madison Avenue met with a severe accident on last Saturday at Lincoln Falls, Pa., by falling upon the jagged edge of a rock, sustaining a fractured rib and other injuries. Advices received by Dr. J. G. Keller of West Monument Street state that Dr. Fleming will remain at Lake Lewis, Pa., for a few weeks, until able to resume his practice.

The *Medical Sentinel*, which is published in Portland, Oregon, is a very progressive and representative journal of the Northwest. It claims to be the only medical journal published in an enormous area extending from a line drawn from San Francisco to Denver and Omaha on the south, from Omaha to St. Paul on the east, to British America on the north and the Pacific Ocean on the west, which looks to be about one-fifth of the United States, while 220 journals are published in the remaining four-fifths.

The Colorado State Medical Society has offered a prize of $100 for the best essay on the diagnosis of tuberculosis by examination of the blood. Preference is to be given to the detection of the pre-tubercular stage. The prize is open to any essay written in the English language, condensed to read in thirty minutes' time; and the award is to be reserved for an essay deemed sufficiently meritorious, that is, one giving rules for the diagnosis to be made from the blood alone, without the patient being seen. The Prize Committee consists of Dr. Charles Denison, H. A. Leman, both of Denver, and Dr. S. E. Solly of Colorado Springs.

BOOK REVIEWS.

HUMAN PHYSIOLOGY. By John Thornton, M. A., etc. With Two Hundred and Sixty-eight Illustrations, some colored. New York: Longmans, Green & Co., 1894. Pp. 436. Price, $1.50.

This is a very excellent work on physiology without any especial merit. The language is clear and the illustrations are abundant, and what is more important, in the right place. It is very thoroughly prepared and the latest theories are noticed. The chapter on histology and the anatomy of all the organs and tissues are very full. In the appendix, among other things, there is a list of progressive questions, original and selected. The book belongs to a series of advanced manuals. The press work is very good.

A HAND-BOOK OF DISINFECTION AND METHODS FOR THE PREVENTION OF CONTAGIOUS DISEASES. By E. T. Duke, M. D., Secretary of the Board of Health of Cumberland, Md. Cumberland, Md.: Harry K. Duke & Co., 1893.

This is an extremely valuable little book, which contains essentially all that one need know of disinfection, and is very clearly and succinctly written. The directions are clear and the methods of carrying them out not too complicated. The diseases that may be transmitted from the lower animals receive attention. Dr. Duke has issued a book which is worthy of his position.

REPRINTS, ETC., RECEIVED.

Traumatic Periostitis. By B. Merrill Ricketts, M. D., Cincinnati, Chief Surgeon, C. P., & V. R. R.

Report of a Case of Carcinoma of the Ileum. Intestinal Obstruction Relieved By Anastomosis with a Murphy Button. By B. Merrill Ricketts, M. D., Cincinnati.

Vorschriften zur Herstellung Eiweissreichen Brotes im eigenen Hause. Mitgetheilt von Wilhelm Ebstein in Göttingen. Reprint from the *Deutsche Medicinische Wochenschrift.*

The Reactions of Nucleo-Albumin (Erroneously Styled Mucin) with the commonly Employed Urinary Albumin-Tests. The Difficulty of Distinguishing these Reactions from those of Serum-Albumin, Globulin, etc. By D. D. Stewart, M. D., Philadelphia; Clinical Lecturer on Medicine in Jefferson Medical College. Reprint from the *Medical News.*

CURRENT EDITORIAL COMMENT.

THE NEED OF ORGANIC STAMINA.

Columbus Medical Journal.

WHEN once the manifold duties and perplexing cares of a successful practice have been incurred, the physician will realize the advantages to be derived from physical strength—organic stamina. The mental anxieties that are the daily and hourly companions of the conscientious physician are a tax upon his strength of which the public knows too little.

PROFESSIONAL ORGANIZATION.

The Philadelphia Polyclinic.

THAT doctors may live and practice peaceably together, co-operate and properly aid each other in the community, it is absolutely essential that they should be brought into personal contact under circumstances where they have most to draw them together, and least to awaken their antagonisms. And these conditions are best fulfilled, or fulfilled only, in medical societies, where the individual interests can be left behind and common professional and social interests be allowed to dominate their intercourse; and the profession of each locality has the need of so much association as may be practicable with physicians residing in other parts of the country, and these needs can only be met by some form of national organization.

A GRATEFUL CHANGE.

New York State Medical Reporter.

THE day of decoctions and infusions is over. The rapid and efficient results obtained from the use of active principles and remedies of standard strength have relegated them to the forgotten past. The small doses required in the case of the active principles and the palatable vehicle employed by the manufacturing chemists have greatly increased the doctor's popularity with his patients, and the children no longer regard his visit as a penitentiary infliction. It would be well for those among the profession who still believe that only mixtures as bitter as the waters of Marah, or pills the size of a bolus, can work good results, to reflect upon this subject, and remember that in this day of progress and improvement they must keep up with the march or be hopelessly left behind.

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NOTES.

FIVE grains of the carbonate of sodium to an ounce of water is a very simple and efficacious gargle.

*

LANOLINE mixes readily with water and adheres to the skin, and for this reason is much superior to vaseline.

*

LAXOL is the name of a new preparation of absolutely tasteless cod liver oil which has been recently put on the market.

*

FLUID extract of eucalyptus is an excellent remedy in whooping-cough. It may be given in an aromatic or in brown mixture.

*

LACTATE of cocaine, one to five of lactic acid and water equal parts, when injected into the urethra greatly relieves the pain in cystitis.

*

IT is said that impurities in the bromides prevent their acting as they should and account for some of the failures when given for nervous troubles.

*

IN carbolic acid poisoning, sulphate of sodium or Glauber's salt is the most effective chemical antidote, forming the harmless sulpho-carbolate of sodium.

*

CHLORATE of sodium is recommended in the treatment of carcinoma of the stomach. It is given in doses of four to eight drachms a day except when there is albuminuria.

READING NOTICES.

Celerina.—Ox-gall, one grain of the inspissated, with one drop of oil of wintergreen to one teaspoonful of Celerina, will relieve headache. The remedy may be repeated every hour.

*

Habitual Miscarriage.—R. Reece, M. R. C. S., Eng., 1851, L. S. A., 1832, Walton-on-Thames, England, says: I used Aletris Cordial in a case of painful menstruation. It was most valuable. The wife of a minister suffered much and had had three miscarriages. Prescribed Aletris Cordial. She has, for the first time, gone her full time, and was safely confined with a male child. I also prescribed it to a relative, suffering with leucorrhea for years. Great relief from pain, and the discharge much less. In the first case related it was truly a God-send to her.

*

Hæmoferrum.—Wherever introduced it has been warmly received by the medical profession, and has the cordial endorsement of the most prominent physicians in Detroit, in which city it has been thoroughly tested clinically. Dr. Hal C. Wyman, Professor of Surgery in the Michigan College of Medicine, states: The Pilloids of Hæmoferrum (Stearns') have in my hands proven a splendid tonic. In wards of the Detroit Emergency Hospital we have learned to depend upon them in the preparatory treatment of patients who must undergo severe surgical operations, and they have proven useful in the establishment of convalescence.

*

Hypnotic Medication.—In reviewing an article with this title by Dr. Jasiewicz (*L' Union Médicale*), Dr. C. G. Cumston (*Annals of Gynecology and Pediatrics*, July, 1894) says that this is a subject of interest to gynecologists, who are often at a loss to know what to prescribe for nervous women suffering from insomnia due to particular excitations of the nervous system, without any special organic lesion, as in neurasthenia, the different neuroses, etc. In the paper referred to above, which was read before the Therapeutic Society of Paris, Dr. Jasiewicz remarks as follows regarding the therapeutic effects of Sulfonal: Sulfonal is only slightly soluble, but C. Paul was able to show that in the organism during digestion the presence of salts and peptones favored dissolution and absorption of the drug. It is perfectly harmless as regards the heart and respiration.

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ORIGINAL ARTICLES.

MEDICAL LEGISLATION.

THE ANNUAL ORATION DELIVERED BEFORE THE ALUMNI ASSOCIATION OF THE COLLEGE OF PHYSICIANS AND SURGEONS, APRIL 18, 1894.

By H. H. Longsdorf, A. M., M. D.,
Dickinson, Pa.,
Fellow of the American Academy of Medicine; President of the Cumberland Co., Pa., Medical Society.

Gentlemen of the Alumni Association:

In accepting the duty which you so kindly laid upon me of addressing you on this occasion, two considerations were present in my mind. The first was the honor involved in such a duty, and second, my inability properly to discharge it; for that it is an honor to stand in this representative position, before a body of fellow-workers and associates in a common cause, under the banner of a common Alma-mater, no man will gainsay; feeling this I heartily thank you for the privilege.

As for the second, I will only say that the exigencies of a busy professional and business life, such as the country practitioner often finds it prudent to combine, have left me too little time to keep equal pace with those of higher endowment and more exclusive devotion who have heretofore so worthily represented you in this place.

Begging your indulgence therefore if my remarks fall short of your usual standard, I will proceed briefly to consider a subject which has recently given me some food for thought and which is of perpetual interest to the physician, and through him to society at large. I refer to the need and importance of legislative action in medicine, either in the department of medicine proper, or of some sanitary expedient of greater or less utility, or of some ethical suggestion, or of any of the many cases where the two learned professions most closely related to each other and to the public weal find it necessary to join hands in the accomplishment of an object.

Such legislative action has marked and confirmed each noteworthy era in the history of medicine, and if through any word of mine falling upon so fruitful a field as this, further and larger concessions should be obtained to perfect the cause which we have been taught to consider a mission—the uplifting of humanity to a higher plane of thought and action—the time will have been well spent.

In seeking to impress upon you the more salient points of my subject, I will follow as far as I can the indication of the times and the practicability of the measures proposed. It has seemed to me that the trend of professional progress to-day is in the direction of:

1st. Improved Sanitation.
2nd. The Care of the Insane and Defective Classes.
3rd. Social Purity.

Under these heads is comprised the physical, mental and moral well-being

of man in all his relations to life, and as no one so well as the physician comprehends the enormity of the task, so also no other is so willing and able to undertake the work of regeneration and enlightenment. Into the area of this work legislative action has come from time to time, and although it has sometimes seemed to rob the ordinary practitioner of something of the dignity and prestige of his professional status by unscientific methods and the all-prevailing system of political preferment included in the enactment, yet in the main it has been a benefit. The arguments presented from the physician's standpoint, assailing ignorance, dispelling superstition, arousing the instinct of self-preservation, would have been in many cases fruitless had not the law clinched them and brought them home barbed with a penalty.

In former times, when knowledge was in its dawn and science had not yet probed the mysteries of nature, life was held less sacred than it is at present. War decimated the nations, pestilence followed its ravages to complete the work of destruction, slavery subdued the impulse to live, famine and ignorance of the arts and appliances for sustenance and protection, all helped to threaten the human race with extinction. As time went on and the evolution of intellectual supremacy placed man more emphatically at the head of creation, an instinctive self-respect grew upon him, and the safe-guards of preservation were strengthened by all means within his reach. Disease was no longer looked upon as the vengeance of a malevolent deity and therefore beyond the reach of mortal alleviation, or as the outbreak of some demon imprisoned in the tortured body or, at a comparatively recent period, as a disciplinary penance imposed by a supernatural being anxious to subdue a refractory subject. All these ideas were fostered and engendered by the spirit of bigotry and error which prevailed at that time. The natural outgrowth was a rude remedial system and incantations, magical art, fetich-worship, charms, philters and various religious rites all held sway at different periods in the vain effort at relief from diseases caused mainly by filth and the lack of thorough knowledge. Even yet, in the brilliant light of the present century, there are lingering fragments of these broken systems of the past. We find them in hidden corners where a black cat is still looked upon with a certain respect as possibly a transformed witch, where a silver bullet fired under prescribed conditions still has efficacy in arresting or diverting the course of the destroying angel, and where certain obstinate diseases as rheumatism and that mysterious infant-ailment called in the Pennsylvania idiom the "ab-nemet," are still treated by a series of legerdemain and pow-wowing. We find them also in more highly cultivated circles who, affecting a superiority to the ordinary laws of matter, spurn the idea of materialistic subjection and rise above physical weakness, in the realm of the Christian Scientist and Faith-healer. But though the world is slow to accept the responsibility of enlightenment, truth, especially scientific demonstrable truth, will make its way, and as each successive discovery in the divine art of healing was given to the world, it was hailed with joy, and medical science was lifted to its rightful pedestal.

The physical well-being, in other words, the health of the race, is paramount to every other consideration, for upon it everything of a substantial good depends. Achievement-empire in any field depends primarily on personal strength reflected in prowess and thirst for action ; on the thoroughly regulated machinery of the body measuring out wholesome impulses to heart and brain, reflected in a pure life and a genuine appreciation of its purposes. No nation has reached or retained supremacy without regard to this factor, and we have a lesson of warning and instruction in the disintegration and downfall of such as have neglected it. When the respect for physical strength was at its highest, then were produced those immortal works over which the classic reader still delightedly lingers, then were accomplished those victories on the field of arms, which still thrill us with a kind-

ling enthusiasm. Greek culture was the outgrowth of perfect health. Debauchery and excess, the idle languor, which, as in some of our own leisure classes, despised even the games which held the taut sinews in place, the splendid vitality of the Greek before he fell an easy prey to the ruder but stronger rivals watching from afar his waning powers, and noting the vulnerable point which might have been guarded. So, too, the proud Roman had to undergo a prolonged course of physical enervation from luxurious living, before he was swept into an undeserved oblivion. History repeats itself, and as the physician by his work is related to every living interest that can touch humanity, it comes within his province to multiply these warnings and point out the needful measures for the protection of society until his end is obtained, even though he should repeat over and over again truths so trite that "he who runs may read."

> "The broad advances of material power,
> The onward sweep of universal good.
> And Nations moving into manhood new
> Through wisdom and authentic civil change"

need not then be merely the dream of the visionary, but the actual result of a faithful observance of nature's laws. The inculcation of these laws to the general public and their enforcement through governmental means is the business of the physician and never more than now. And if he practically stands alone and unaided, without an organized system, or a share in congressional influence, it is the fault of our political policy rather than the lack of importance in the claim. Why our administrative government does not include a Health Bureau, with its ramifications extending throughout our body politic, officered and equipped in accordance with the latest demands, is a question which I will not attempt to answer. And if the preservation of the public health is the highest charge of a protective government, where in the scale of honor and emolument shall we place the man who administers it? Should the political schemer outrank the disciple of Esculapius when he it is who holds in his hands the real talisman of power? Surely in this presence I will be pardoned if I digress in paying respect to the profession here represented. And if what I say seems in the nature of a panegyric, I am equally sure that it will find an echo in many hearts here present who best know the toils and cares that beset a physician's life. If I could at this moment annihilate space and lift the curtain that shuts in the ordinary practitioner in his daily rounds and the devoted of an absorbing science, in a more restricted but not minor field —in the laboratory—the study—the dissecting-room—by the bedside—wherever engaged in his special line, he might be found, seeking some newer or more efficient remedy or appliance or deduction whereby the sum of human loss and suffering might be lessened, thinking of no patents to enrich him, claiming no exclusive right to the material benefits that may accrue, picturing no honored place in legislative hall or official cabinet, scarcely looking forward to the legitimate reward of acknowledged merit, I could show you better than in words the wide domain he controls and the self-effacing spirit he exhibits. If "an honest man is the noblest work of God," the honest physician is the noblest product of our civilization.

"No man liveth to himself," is the principle which lies at the basis of society and no man so entirely responds to it as the physician.

From the outset of his professional career he surrenders himself to the spirit of this maxim and, whether consciously or otherwise, becomes the self-constituted guardian of the myriads of human beings who people that vast estate which has a circumference of twenty-five thousand miles and extends from pole to pole. His jurisdiction reaches to the farther limits of time, where he so often stands to witness the flight of that ethereal part which his art cannot control and where the question he oftenest asks of his inner self is "Have I done *all* that could be done?"

Considering him then as an integral part of this vast community, what is

the first step of the thoughtful physician? It is that of any wise general with the challenge of battle before him in an enemy's country. He studies his environment and resources. He finds himself surrounded on all sides by antagonistic forces the nature of which he but dimly comprehends and consequently can only imperfectly combat. He finds the water supplied to many thousands of human beings full of micro-organisms as deadly and almost as swift in their effects on the vital structures as the bullet or the lightning-stroke. He finds the air that so deliciously fans the brow or cools the boudoir of the belle of the season, vitiated and impure from having first passed over miasmatic or infected districts, or exposed to conditions destructive of the normal composition of the most universal factor of health. Death follows in its wake, and one victim prepares the way for many more, and we have, alas, the so frequent spectacle of a community stricken down by a contagious disease that might have been avoided.

The food supply is no exception. "Death is found in the pot" so often that it ceases to cause comment further than perhaps to point a paragraph in the daily newspaper. Not long since numbers of guests at a wedding in Boston fell ill and several died, the cause being traced to the use of poisonous vessels in the preparation of the food. It is still more common to hear of fatal results from canned meats, from ice-cream and from many other similar sources all obviously under the control of a more rigorous system of commercial inspection and therefore preventable. It is hard to realize the indifference that exists on these subjects and the false economy practiced in quarters where we look for something better. The public has a cheerful confidence that in respect to sanitation and its outlying interests all has been done that learning backed by unlimited resources can do. And the average citizen points with pride to the elaborate array of boards of health and the energy displayed in carrying out their requirements.

But that these organizations, indispensable as they are, do not invariably prove efficient, or that they neglect to reckon upon the eye service found in all delegated work, is shown in a recent occurrence in the City of New York, where we might reasonably expect thoroughness.

Permit me to read the following extract from a prominent and reliable newspaper :

"Under the leadership of one woman possessing extraordinary executive ability has been carried on almost secretly a very great work in the way of distribution of charitable aid, she representing that committee of millionaires appointed by President Seth Low to raise funds and devise means for alleviating distress. She speedily discovered that the poor were suffering almost as greatly from *dirt* as from lack of food. She sent out a corps of nearly 300 workmen with sanitary appliances and plenty of whitewash, and there are hundreds of tenements in this city to-day that are clean, which had not been clean since they were erected. Some of the discoveries of her subordinates seem incredible. From the cellars of four tenement houses they took away fifty cart-loads of foulness, and from one cellar of one tenement, twenty-five cart-loads. Another company of women are after the stables of New York City, and they have statistics to show that the mortality in the vicinity of stables is sixty per cent. greater than in those districts where there are none. They have a bill reported favorably to the Legislature to compel the stable owners to bale up, compress and ship away all stable refuse, and the stable owners of New York have raised a fund of nearly $50,000 to *beat* the bill."

The briefest comment which can be made on this showing is, that if sanitary legislation is so urgently needed in New York, and what has been done there in the past year while under the influence of the cholera scare has proven so ineffectual, how must it be in cities less conspicuous for wealth and general resources ? If New York, with its portals swung wide for the ingress and egress

of the thousands who daily pass through from sea and land—the boasted metropolis of all that is best in our American civilization, can be so derelict at the opening of the danger-breeding season, what may we not fear as to the outcome for the summer in other less protected situations? The inference is obvious: if the larger centers of infection are not persistently guarded, the lines of communication to other places with little or no protection would speedily disseminate it.

Into this question comes the perennial interesting question of immigration, though I fear it will provoke a smile from this assemblage to recur to a subject so well-worn. But facts are stubborn and will not down at the wave of the hand and one of the most stubborn is this of our too complaisant disregard of the public safety from this source. That typical genius of universal liberty which every American loves, in fancy, to contemplate, as standing astride the continent with one hand outstretched in welcome to the East, the other to the West, has too often neglected to bar the avenues of entrance to the disease germs brought from foreign shores. Again and again have we been threatened with an invasion of cholera, yellow fever and leprosy, traceable to this cause, and again and again has the discussion arisen as to the wisdom of unrestricted immigration. So far the vigilance of our local authorities has kept the danger aloof from our homes, but one careless or neglectful step may precipitate it upon us. In this connection we cannot help expressing admiration for the prompt and thorough measures taken for the protection of our metropolitan cities during the late threatened scourge of cholera. Here could be seen the effects of wise and energetic legislation stimulated by the investigation made abroad, as to the cause of the disease and the power of sanitary precautions to restrain and prevent its propagation. Did the limits of this article permit, it would be interesting to follow up the more recent researches and discoveries by the devoted student of this most evasive plague. It remains a fact that we have not a little yet to learn concerning the etiology of cholera. The specific influence of the comma bacillus may or may not be disproven, but the field is a wide one, and it would reflect credit on us as a nation, and further our triumphs of science, if our government would offer special inducements and furnish more complete facilities for study and experience towards the end of more demonstrable knowledge in this field. Our imperfect knowledge thus enters into the question of the efficiency of measures taken by the sanitary authorities. We do know that the disease is always brought by the immigrant. Every epidemic the country has ever known has been so introduced, not by the person of the immigrant, but by his effects and baggage. The disease travels as fast as a man travels and no faster. It follows regular routes, that is by commercial lines. When once started in a place it speedily develops. These facts show that it is a material thing which could be transported, that it was a living thing that would grow when planted, and would reproduce itself and nothing else. So, the sanitary regulations can be modified to suit the case, and as I hinted the old question of the prudence of unrestricted immigration arises. It is a separate question from that of sanitation. The thoughtful publicist looks at the foreign population in the almshouses and jails and hospitals, and for the good of the country he desires to restrict immigration. But with the physician and the sanitarian, be he physician or not, it is simply a question of the adequacy of the facilities for handling of all these incoming people who may be carriers of disease. It is true that the character of the immigrants coming to our ports has changed. The bulk of the immigration is no longer composed of the sturdy, energetic, clean and ambitious class which formerly sought our shores to found honest homes—and we confess a fear for our institutions as well as the more immediate danger to the public health, when we look at the record which the present immigrant soon makes among us.

Leprosy is a form of imported disease

which needs to be rigidly scrutinized. That comparatively little fear is felt of this loathsome disease is doubtless due to the fact of the immunity of this country from its ravages, and that a general ignorance prevails even in well-informed circles of its nature and history. The system of isolating the leper in countries where it may be said to have its natural home has contributed to this. A recent writer who has made a study of the subject declares that in Russia, Norway, Spain and France, leprosy is increasing steadily. In Russia particularly it is spreading so rapidly in the Baltic provinces especially, as to seriously alarm the authorities. In Asia the increase has been even more remarkable, and in India it has increased at the rate of 30,000 in every ten years. In Bombay alone it is estimated that there are 1000 cases of leprosy at large and it is no uncommon sight to see lepers publicly dressing their sores in the streets. Sir Andrew Clark, in a public address given a few years ago, stated that he could produce overwhelming testimony to the fact not only that leprosy exists within the old localities in larger measure than formerly, but, that new germ-centers were springing up in various quarters.

Considering the vast amount of intercommunication between these countries and ours, it is of great importance that stringent means should be taken to prevent so foul and insidious a disease from finding permanent lodgment among us.

We turn from these remoter perils which happily can be kept at bay by the faithful use of the means already put into our hands, to those which literally dog our footsteps and haunt our very firesides ; the contagious diseases which fall into every day practice and which are due to organisms produced by unsanitary surroundings, and which are often so cloaked and concealed by circumstances that they are as difficult to deal with, as formidable in character. To the medical man, the aspect of these invisible monsters is sufficiently familiar. As he goes his rounds from bedside to bedside where lie the victims of a guilty ignorance, or a guiltier neglect, he sees beauty fading into decay; manly vigor yielding to premature debility ; the roseate dawn of childhood changing into the hues of night ; he witnesses the agonized struggle of nature to restore the equilibrium of waste and repair ; he hears the wail of despair as hope recedes, and the fatal end approaches, bringing to him the humiliation of *defeat* instead of pride and confidence in his heart which ultimately succumbs to the foe he cannot vanquish. And why must this be so ? Why is it such a frequent experience for a physician to be left powerless to arrest the commoner contagious diseases, until one case grows to two, to three, to become an epidemic which desolates families and impedes the ordinary vocations of life ? Simply because legislative action has lagged behind scientific enlightenment. Where ignorance is intrenched behind immunity from penalty, neither reason nor logic will prevail. Refuge is taken in the absolute and inalienable privilege of the individual to do as he pleases with his own ; he scouts the theory advanced as to the cause, and he cannot comprehend that it is a crime to endanger the life of another by indolence or stupidity, and if loss and affliction reaches his own family circle the burden is philosophically divided between a long-suffering Providence and the medical attendant, while the origin of the trouble remains untouched.

In such a case he should have plenary powers to command instead of to request the abatement of the suspected nuisance. He should be just as able to call in the constituted officer for such a duty, to remove a dangerous cess-pool or close a drain which may be carrying contamination to a reservoir, the water supply of a town, as to call on a policeman to check an assault or stop a fleeing burglar. Or recognizing the enemy in some other guise he ought to be able without *friction* or *personal objection* to demand security for his patient from the emanations from some broken sewage pipe connecting with a bath-room, though the house would have to come down, from the noxious infiltrations of adjacent soils,

which poison the air, from the danger-breeding vicinity of a cemetery where the burial of our beloved dead is too often left in the hands of irresponsible parties ; from a too brilliantly lighted hall disturbing the proportions of healthy air, from an ill-ventilated school-room or more frequent still from the slumber-provoking atmosphere of a fashionable church where the cushions and draperies and general architectural arrangement might fittingly serve to emphasize the warning of the preacher: "Put thy house in order ; for to-morrow thou shalt die ;" from the contagion-holding plush and velvet chairs of our railway *conveyances*—from all and every form of abomination sustained in our modern system of living, falsely called refinements. From these and the evils that are their outgrowth, let the law deliver us, not theoretically, but actually, in any manner necessary. If a foreign foe were to threaten us with war, how long would it be before from Maine to the Gulf, from Behring Sea to the mouth of the Mississippi, on our coast line would bristle with defences ? How long before every man with a spark of patriotism in his breast would leap to offer life and treasure to repel the invader ? But the foe that lurks in the glass of water for our refreshment, in the milk we offer our babies, the foe that sits grinning at our table, that meets us in our work and goes with us to our places of amusement ; the foe that nips the bud and blasts the bloom of our population—to that foe we give "ample scope and verge enough" to work his will, without let or hindrance, except possibly the groan and *unheeded* protest of some pessimistic scientist. Let the physician, the ideal guardian we have so imperfectly sketched, go clamoring to the door of the legislative chamber and never take "No" for answer until he is given all power to deal with the problems that enter into the factorage of human ills. Better for the race that we return to some of the savagery of the past than weaken and wither under an effete civilization.

[CONCLUDED NEXT WEEK.]

MEDICAL TUBERCULOSIS.

READ BEFORE THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

By Hugh Hamilton, M. Sc., M. D.,
Harrisburg, Pa.

MEDICAL tuberculosis is limited by the exclusion of those cases which by surgical interference can be relieved.

Presuming that the constant factor of tuberculosis is the bacillus tuberculosis, its bacteriological determination is essential for the diagnosis of the disease. Having now indicated the field of the subject, it becomes easy to discuss briefly the several forms that demand treatment. The almost invariable presence of the bacilli in those afflicted with phthisical complaints makes one wonder if the bacillus tuberculosis is the universal cause of this fatal condition of the human organism. The system is affected with more or less rapidity not always in accordance with the physique of the individual.

The studies of Koch brought out an immense amount of information, although his original purpose was frustrated and his benevolent hopes unrealized, yet the publication of his postulates stimulated extensive and active research with sure principles upon which to formulate methods of treatment. A digression is made at this point into some of the effects of bacteriological growth and products. The simple growth of vegetation requires heat and moisture. The fungi bacteria require heat and moisture. They secure it at the expense of the normal physiological function that necessarily produces pathological physiological performance. This pathological condition is noted by irritation that shows its presence by sensitive degrees of febrile movement.

The alteration of the albumen present in the body into forms (chemical formula), which before the introduction of

germs (bacilli) were innocuous, become through its parasitic existence, toxic—even to the bacterium itself. The object of germ life is to perform a vital cycle—probably best illustrated in vinegar, which live in great numbers in cider, by the germs and by their presence and animation change the saccharine material, through the alcoholic, to the acetous fermentation.

The process of making bread by yeast is another familiar illustration of this fact, stopped in its process by baking heat. Domestic wines are made this way, by stopping the fermentation in the alcoholic stage. Now observe that both *vinegar* and *alcohol* are antiseptics, preserving from decay vegetables and flesh.

Now the products of certain bacteria are *indol* and *phenol*—"antiseptics" we call them—should they in their cycle of living produce these by-products beyond the normal, they would cease their active career, provided no new albumens were offered for their consumption.

The *Tuberculin* treatment of tuberculosis disturbances in the coarser tissues was to a degree successful. Was it because those muscular tissues were firmer and changes in them slower? The application of these by-products locally in lupus, etc., had singularly fair results. In the lung tissues of a finer and more delicate character, it was impossible to reach the nidus of disease without also exciting an intense influence upon the general system. Whether the balance of the by-products to the life of the bacilli in lupus was so disturbed as to destroy the bacillus tuberculosis remains beyond my ken—but it is a thought.

An alga in water previously used by an alga dies from its constantly used supplies of nourishment, and the excretions or by-products of its existence. Analogically, an animal would die in a closed vessel from the inhalation of his own exhaled carbonic dioxide—a by-product.

The art of the Japanese horticulturists that produce dwarf, undeveloped fruit trees is well known. Can we stunt or stop the growth of these parasites by cutting off their supplies? We have succeeded in surgery to such an extent that the continuity of healthy tissue is separated and repaired at pleasure by following the simple rules of modern surgical practice. There is no pus in pure surgical interference. "Healthy pus!" who ever hears that phrase now?

Strümpel, measuring the irritation in consumptives, from the febrile movement observed in the thermometric records, divides them into five classes:

Classes.	Morning.	Evening.
I. Sub-fever	N	100.4 to 101.3° F.
II. Hectic intermit.	N+	101.3 to 104.
III. Remittent	100.4–101.3°F.	103.1 and upwd.
IV.	Continuous	Fever.
V.	Irregular	Fever.

When we change the climate by altitude or latitude, *i. e.*, returning the individual to his geographical place, we allay the ravages of the bacilli for a time.

We attempt and succeed when we send persons to the dry Colorado plains or the altitudes coverd with balsamic pines. Where these are not possible, the application of the several essential (odorous) oils or their acid derivatives inhaled regularly, with generous diet and discipline of the general habits, we find an average rising from 50 to 80 per cent. benefited and have their lives prolonged. The United States is rich in varieties of climate suitable for persons with pulmonary disease.

Respecting the contagiousness of tuberculosis there can be no question. The German police ministry promulgated detailed orders in 1891, which have been copied; and we are now agitating the populous cities of New York and Philadelphia to adopt them. The enforcement in Germany of this proclamation has already attained gratifying results; and the next twenty years will testify to its great wisdom. Compulsory vaccination has almost eradicated variola from the schedule of the national calendar diseases of Prussia.

To sum up this matter:

1. Bacteriological diagnosis of the disease is essential.

2. The pathological process offers inducements of success in germicidal local treatment—which has succeeded so efficiently in modern surgery.

3. That the febrile movement should be diligently studied, both without and with active treatment, as insisted upon by Strümpel.

4. That climatic and sanitary conditions are necessary in the whole individual.

5. That every effort toward preventing the dissemination of dried sputum should be used.

THE CONTAGIOUS ASPECT OF PULMONARY TUBERCULOSIS.

Read Before the Medical Society of the State of Pennsylvania.

By A. M. Cooper, M. D.,
Point Pleasant, Pa.

As there is so much being said and written about the contagious nature of pulmonary tuberculosis, I turned to my experience and observations for almost four decades to see if I could satisfy myself which side was tenable; I confess I was somewhat skeptical about the contagious nature of the disease before I investigated the matter and am more so now. However, my mind is open to conviction and change of opinion, whenever facts sufficient are presented to warrant the change.

The late Prof. J. K. Mitchell used to tell the class, that, where the consort was taken with consumption and died, the surviving partner was more likely to follow with the same disease than under any other circumstance in life. The intimate relation that existed between husband and wife, the well one was much more likely to become *infected* than under any other relation or condition. The word *contagion* was not thought of 40 years ago in this connection.

I collected all the cases that I had attended, professionally, or who had come under my personal knowledge and observation and I found fifty-five such cases, when husband or wife had died of tuberculosis of the lungs with the following results to the remaining consort.

Fifteen husbands died of consumption of this number, and their wives are still living and well. Some have since remarried. One husband died about one year ago—one, three years ago and the remaining thirteen from six to thirty years ago.

Of the above fifty-five cases, twenty-five wives died from consumption of the lungs and their husbands are alive and well now.

All these wives have been dead over six years, and some of them over thirty years.

Three husbands died of consumption and their wives lived many years thereafter (one over thirty), and died of *old age* or some other disease.

Seven wives died of consumption and their husbands all lived to die of some other disease, and all died more than ten years after their wives.

Mr. M. died April 17, 1870, of consumption, and his wife died of the same disease, March 28, 1884. The wife following the husband fourteen years after his death from the same disease. Rather a long stage for incubation.

Mrs. S. died of consumption in the fall of 1872. Her husband afterwards remarried and died of the same disease in the spring of 1880—eight years later. The second wife has since remarried and is yet living and well. One case more which is peculiar.

Mr. and Mrs. B. were married in 1871. She not strong. He able to work, but coughing. She gave birth to twins Aug., 1872. The children lived a short time and both died, she never regaining her former health, but developed consumption in its rapid form and died in Jan., 1873. The husband died two or three years later, from consumption, which had been of long standing. Mrs. B., on her mother's side, was from a consumption family. As far as I know it did not exist in his family.

The last case is the only one in the 55

where there could have been any contagious influence exerted and that remains extremely doubtful. I am yet inclined to the opinion that heredity has more to do in the causation of pulmonary tuberculosis than anything else. I care not whether the germ of the disease is inherited or the productive soil, a fit and proper habitat for their implantation, development and multiplication, the fatal effects of the disease will be the same.

Ovariotomy During Pregnancy.—In the *Archive de Tocologie et de Gynécologie* there is an article mentioned in the London *Lancet* by Dr. R. Condamin on the treatment of ovarian tumors complicating pregnancy, with an account of two cases of the kind which had come under his notice. The question discussed is at what period should ovariotomy be undertaken: should the operation be undertaken during pregnancy as soon as the tumor has been detected, or not until after the confinement? Dr. Condamin's two cases point to the advantage of operating as soon as the tumor has been discovered. In one of them ovariotomy was not performed till about three months after the confinement, and in that case the patient had become very ill before the operation was undertaken, with great pain and high temperature. When the abdomen was opened the pedicle of the tumor was found to be twisted six or eight times, and the appearance of the cyst wall here and there suggested that gangrene was about to supervene. The patient recovered, but from the account given it is evident that her condition was during part of the time such as to cause anxiety. Dr. Condamin believes that the lax condition of the abdominal walls naturally resulting after labor is an important factor in facilitating twisting of the pedicle when there happens to have been an ovarian tumor complicating the pregnancy. In the other case related ovariotomy was undertaken at the fifth month of pregnancy; the operation was perfectly simple and the after-history uneventful. It is not, however, expressly mentioned whether or not the patient went her full time. Dr. Condamin refers also to the series of post-partum ovariotomies published by Dr. Lawrence last year, and he considers that an examination of the details of these cases strongly supports the conclusion to which he has himself arrived.

* * *

Fixation in Fractures into Joints.—Dr. Ansel G. Cook of Hartford advocates in the *International Journal of Surgery* the fixation of bones in the treatment of fractures into joints and maintains that there is no fear of ankylosis. His conclusions and rules of treatment are :

1. That bony or serious fibrous ankylosis is the result of injury and subsequent inflammation and not of immobilization.

2. That early passive motion only disarranges the fragments of bone, thereby increasing the production of callus, that it irritates the injured ligaments, and, by increasing the inflammation, tends to produce the ankylosis it is thought to prevent.

3. Immobilization is useful *only* when active inflammation is present, or until the ruptured ligaments and broken bones have thoroughly united.

4. The logical treatment of a fracture into a joint, therefore, should be rest and local applications to reduce inflammation. Reduction of the fracture as early as possible, then immobilization until the bones and ligaments have united (from three to eight weeks, or more, according to circumstances).

5. Passive motion, massage and use till the tissues become normal, or, if the massage fails, complete rupture of all adhesions under an anesthetic. The factors which will ultimately determine ankylosis are the nature of the original injury, the character and duration of the subsequent inflammation, the destruction of bone and cartilage, cicatricial contraction of the soft tissues around the joint, and the age and condition of the patient.

PREPARING THE HANDS FOR OBSTETRICAL WORK.

By Edward Anderson, M. D.,
Rockville, Md.

I HAVE been for some time past, when called to a case of abortion or labor at full term, in the habit of first washing my hands in coal oil and then in warm water, the whole time occupied not being over three minutes. Time is often of great importance when hemorrhage is profuse and as kerosene is to be found in every household, there is no time lost in procuring it. After preparing my hands in the above described manner, I curette the womb with my finger nail in incomplete abortions and manipulate it in any other way that is necessary without fear of sepsis. Petroleum is of a most penetrating and detersive nature; it will loosen a tap from a bolt in a few hours that has been rusting on it for years.

Coal oil was used by the Persians for illuminating purposes over two thousand years ago and may have been used in obstetrical practice also, but I have seen no mention made of it and I do not believe it is even now in general use, if used at all, for the latter purpose.

MEDICAL PROGRESS.

MASSAGE IN GYNECOLOGY.—Rapid advances have been made in the department of gynecology and also in the methods of practicing massage. Dr. Oscar J. Mayer has used it in a number of cases with great satisfaction to himself and his patients and his conclusions from his paper in the *Journal of the American Medical Association* are as follows :

Massage is valuable in parametritis and hemorrhagic infiltrations, in that it causes quicker and more complete removal of the exudations. It is valuable in causing absorption of contracted hypertrophied pelvic connective tissue, be it the remains or sequelæ of acute pelvic cellulitis, or be it due to an idiopathic circumscript chronic thickening. Massage is a therapeutic agency of high potency. It is very effective in combination with other therapeutic measures, such as baths, douches, medicated tampons, etc., and we often notice that where these remedies have been resorted to with failure, by the use of massage alone a permanent cure will be obtained. The best and quickest cures are observed in chronic diseases following the puerperal state ; while a longer time is required in diseases following acute inflammatory processes, also when coincident with anomalies of position of the pelvic organs, especially in retro-deviations of the uterus.

In chronic perimetritis, the results, while not so good as those observed in parametritis, are encouraging enough to warrant the use of massage, since resort to the operative procedures does not accomplish more for the patient. The same may be said of anomalies of position of the pelvic organs accompanying perimetritis.

In retro-deviations of the uterus due to adhesions or relaxation, massage is a remedy not to be underestimated ; the indication for its use depends on the causes of the malposition. In these cases massage is free from danger and gives more satisfactory results than all procedures requiring force. Even if we do not succeed in some cases in restoring the uterus to its exact normal position, we can obtain a symptomatic cure without recourse to surgical procedures. The time required for reposition of the uterus is usually short ; on an average of a month to a month and a half. In all cases that have their origin in the remains of inflammatory products or exudations, massage is invaluable.

The combination of massage with electricity is to be recommended in relaxations of supports of the uterus, provided the structures are intact ; (perineal and vaginal lacerations, etc., have to be repaired). In senile atrophy the action of massage is very transitory. In retroversions and retroflexions, massage gives more favorable results than any of the older remedies. The time required to cure prolapsus and retroposition of the uterus is sometimes quite long, de-

pending on individual dispositions. At times, especially in bad cases, a pessary is required to support the uterus. By exercising proper circumspection, we can often achieve more by alternating massage treatment with other treatments than by long continued massage.

In conclusion, I have to say that massage does not set up for itself the claim that it constitutes an independent and sufficient form of treatment. It is only a mechanical therapeutic agent, intended to be used in combination with other tried and accepted remedies, in effecting a permanent cure, or in considerably lessening the time formerly required therefor. American gynecologists have been somewhat slow in accepting massage as a new remedial agent to be employed in diseases of women, and have been suspicious of the beneficial results that have been claimed for it. But the constant encouraging reports of European authorities, many of them erstwhile bitter opponents of massage, reports that are full of successes beyond the expectations of the most sanguine, are bound to work a change in this American sentiment. The skepticism of to-day will soon be converted into the faith of to-morrow.

* * *

Operation For Fibroids.—The operative treatment of fibroid tumors of the uterus may, according to Dr. Franklin H. Martin, in the *Journal of the American Medical Association*, be considered under three heads: 1. Hysterectomy; 2. Removal of the appendages; and 3. Vaginal ligation of the broad ligaments. The objects of this last operation are:

1. To deprive by a comparatively simple procedure an abnormally overnourished uterus of the bulk of its blood supply by ligating the main channel and trunks of the uterine arteries.

2. To still further deplete the uterus in desperate cases by including, where practicable, not only the uterine arteries of both sides, but also the ovarian artery of one side.

3. To cut off the nutrition of the uterus by ligating a large proportion of its nerve communication as well as its blood supply.

The technique is as follows:

1. Patients should be prepared exactly as for a vaginal hysterectomy.

2. Place in an exaggerated lithotomy position and insert two retractors so as to expose the cervix.

3. Transfix cervix with a strong handling ligature.

4. With curved scissors incise the mucous membrane of the vaginal vault to the right and left of the cervix to the extent of about one and one-half inches on each side.

5. Draw the cervix strongly to one side and with the finger dissect the tissue of the base of the broad ligament of the opposite side, free from the bladder in front, and from the rectum behind, until it can be grasped to the height of one and a half to two inches free from all attachments.

6. With a strong handled, curved, pedicle needle armed with a double No. 12 silk ligature, the exposed ligament should be transfixed at its center, the lower ligature tied firmly and the upper one carried to the limit of the exposed ligament and also tied. They should be cut short.

7. Close the vaginal vault incision with a running catgut suture.

8. Treat the opposite side in the same manner.

9. After douching the vagina thoroughly with an antiseptic fluid, pack it loosely with iodoform gauze.

The general conclusions, based on several cases, are:

1. In hysterectomy we have an operation which is bearing the test of time well; in selected cases in the hands of well-trained men it is the only absolute cure yet demonstrated for a certain class of fibroids.

2. The objections to hysterectomy as a cure for fibroids are, the long training necessary to safely equip an abdominal surgeon for this most formidable of pelvic operations, the great rate of this operation in the hands of the tyro, the long prostration, accompanied frequently with nervous symptoms following otherwise successful hysterectomy, its inap-

plicableness to extremely exsanguinated and otherwise reduced patients, and finally its inevitable death rate of at least 5 per cent. in the hands of expert surgeons.

3. Removal of the appendages as an operation for fibroids is usually unsatisfactory, and should not be resorted to except as a last resort in a complicated case where the abdomen has been opened for the purpose of removing the uterus, which operation for some reason has proved impracticable.

4. If the appendages are removed for the purpose of establishing an artificial menopause and for the purpose of reducing small fibroids by modifying their nutrition, make sure to include in the ligature the main channel of the ovarian artery.

5. Vaginal ligation of the base of the broad ligament for fibroid of the uterus is an operation still on trial. As far as we have history of cases to back the theories of the operation it has stood the test.

6. Vaginal ligation of the broad ligament is a minor operation from the standpoint of mortality, and it is a minor operation from the standpoint of immediate and remote shock to the patient. It can be performed on any patient without risk, in almost any condition of physical prostration or weakness, so long as she is capable of taking an anesthetic.

7. The operation is prompt in saving blood. It succeeds in cutting off one-third more blood to the uterus than does the Battey-Tait operation. Theoretically and practically it immediately checks uterine hemorrhages, and at once begins the diminution of the myoma by depriving it of its nourishment.

8. The operation of ligation of the broad ligament does not leave an abdominal scar, does not unsex the woman, as does both hysterectomy and the Battey-Tait operation.

9. There are no good reasons why ligation of the broad ligament should not be an early procedure in all conditions of uncomplicated fibroids of the uterus in which the operation is practicable, even though in a few cases, subsequently, a more radical operation might be necessary.

10. The operation of vaginal ligation of the broad ligament is practicable in all interstitial or moderately subperitoneal fibroids in which it is possible by careful dissection to expose the base of the broad ligament high enough to include in a ligature the uterine artery and its branches.

* * *

Excision of the Initial Lesion.—The early cure of syphilis, if such a thing be possible, is greatly to be desired. Dr. Edmund E. King in the *Medical News* makes a plea for the excision of the initial lesion of syphilis. By the early excision he claims that the disease may be aborted and by a later excision the secondary symptoms are moderated. This excision must be done boldly and the cut edges made to unite by first intention. The system is probably infected subsequently to the development of the initial lesion. The lesion should be excised under the strictest antiseptic precautions and the edges cauterized with pure carbolic acid. In this paper he draws the following conclusions :

1. That the early excision of chancres —that is, within a few hours after their appearance—will abort the disease.

2. That the excision of any unhealed chancre will moderate the subsequent secondary manifestations.

3. That excision constitutes the cleanest, least painful, and most scientific method of treating the lesion.

* * *

Surgery of the Pancreas.—Nimier (*British Medical Journal*) points out that the good results obtained from establishing a fistula between the dilated bile duct and the small intestines suggest the possibility of dealing successfully with obstruction and dilatation of the pancreatic duct by an analogous procedure. Reference is made to a case recorded by Weir of cancerous obstruction of the pancreatic duct, in which it was found that there would not have been any difficulty in fixing the dilated canal to the duodenum. This record shows that cases may occur of dilatation of the

pancreatic duct, in which, as the structure of the gland remains in a healthy condition, it would be possible, with good prospects of ultimate success, to establish a communication between the pancreas and the small intestine. The chief difficulty at present is the impossibility of diagnosing with certainty obstructive dilatation of the pancreatic duct. The presence of fat in the stools, though suggestive of such a morbid condition, cannot prove more than failure of the duodenal digestion due to disturbance of the biliary or pancreatic digestion. The author anticipates that future clinical investigation will enable physicians to diagnose with certainty obstruction of the duct, so that even if a swelling cannot be made out, the surgeon may confidently practice laparotomy, not as an exploratory measure, but as the first stage of an operation having for its aim the formation of a fistula between the dilated duct and the small intestine. The best way of doing this, he holds, would be to use Murphy's button, which has recently been advocated by Terrier as suitable in all attempts to establish visceral anastomosis. It may be found advisable sooner or later to take advantage of the close connection between the pancreas and the duodenum to establish a direct fistula between these two organs, either by opening the intestine at first, and then puncturing the gland in the direction of the dilated duct, or by opening this first and passing a drainage tube from the cyst into the duodenum.

***

Lead Poisoning.—Anker relates in the *British Medical Journal* a case probably of hereditary origin. He first cites reasons why a toxicopathic as well as a neuropathic predisposition should exist. A girl, aged 8, had a blow on the back of the head when three years old, since which time the mind had developed imperfectly. When she was first seen both feet were in the equino-varus position. Of the extensors on the front of the right leg only the tibialis anticus and extensor longus pollicis showed a trace of power. The patient could extend the toes of the left foot slightly; the tibialis-anticus was intact. Plantar flexion was unaffected. Six months later the paralysis had extended to the arms, the muscles supplied by the radial nerve being involved. There was wasting of the affected muscles. The slight spasm and patellar clonus noticed in the legs on the first occasion had disappeared. Four months later there was considerable improvement in the muscles of the hands. No lead was found in the urine by Salkowski. The symptoms corresponded to those seen in lead palsy. It was localized in the extensors, the supinator longus and triceps escaping. The muscles showed the reaction of degeneration, and sensation was intact. The paralysis was flaccid, except for the slightly increased reflexes, etc., seen in the legs at first. The pathogeny of lead palsy is still in dispute. The paralysis here resembled that of a multiple neuritis such as is seen in alcoholic poisoning. The absence of pain and sensation disturbances, the preserved tendon reflexes, although the paralysis was of the flaccid type, and the absence of tenderness over the nerves were in favor of a cord lesion. The course of the disease was against infantile paralysis; the lesion took six months to develop. Sub-acute poliomyelitis is extremely rare in children. The knee-jerks are usually lost in infantile paralysis. All possible chances of direct poisoning by lead being excluded, the disease was thought very probably to be of hereditary origin. The father was a type-setter, and had frequently suffered from lead colic.

***

The Diagnosis and Treatment of Leprosy.—A disease like leprosy, which is not very common in the United States, naturally presents many difficulties in the diagnosis and treatment. While formerly a case of this disease was a curiosity, it must be admitted now that the disease is gradually spreading here. Dr. Prince A. Morrow, in discussing its diagnostic features and treatment, summarizes his views as follows:

1. From the standpoint of scientific therapeusis, a clear conception of the pathogenesis and pathological anatomy

of leprosy is an essential condition in formulating the principles of rational treatment.

2. It is now generally conceded that Hansen's bacillus is the active, efficient cause of leprosy, and that the presence of the bacilli in the tissues sets up either directly, or indirectly through their toxines, the vast array of organic changes and functional disorders peculiar to the disease.

3. There is no substance known to science which, introduced into the body, is capable of destroying the bacilli without destroying the living cells which contain them.

4. Furthermore, from the nature of the pathological changes and the position of the bacilli in the deeper tissues, it is evident that no germicidal agent can be brought into direct contact with the pathogenetic organisms, and hence all treatment which has for its object the destruction of the bacilli is impossible of application.

5. The treatment of leprosy by injections of tuberculin has been disappointing in its results. Experiment has shown that the action of tuberculin is positively pernicious in setting free the bacilli in the tissues and determining the development of new foci of the disease.

6. The treatment of leprosy is essentially empirical; whether, as has been claimed, certain remedies act by virtue of their sterilizing properties upon the living tissues, rendering them unsuitable to the growth and multiplication of the bacilli, cannot be determined.

7. The more or less rapid development of leprosy depends upon the resistance of the tissues to the inroads of the bacilli. In exceptional but well authenticated cases, this capacity of resistance is sufficient to dominate and destroy the pathogenetic microbes, as shown by the observation of abortive cases in which indubitable signs of the disease definitely disappear and never recur.

8. This capacity of resistance may be strengthened by change of climate, improved habits of living, and measures calculated to build up and maintain the general health at the highest standard.

9. Observation shows that the removal of a leper from an infected district to a more favored climate exerts a marked modification upon the course of the disease; there is, for a time at least, an arrest or retrogression of the symptoms. This lull in the manifestations is, as a rule, disappointing in its duration. Of the one hundred and sixty Norwegian lepers who have emigrated to this country, there is no record of a single definite cure.

10. A dry, moderately cool, mountain atmosphere is most favorable in its influence upon the disease. A hot moist climate or a damp cold climate are both unfavorable.

11. A nutritous diet of fresh meat and vegetables, warm clothing, exercise in the open air, freedom from exposure to damp and cold, are important elements in the hygienic course of treatment.

12. The care of the skin by frequent hot baths, massage, with inunctions of oils, etc., should receive as much attention as the constitutional treatment.

13. The special remedies which clinical experience would indicate to be of the most value are chaulmoogra oil, gurjun oil, arsenic, and certain agents of the strychnos family; all are, however, more or less disappointing in their results.

14. All observers agree that in advanced cases, where general dissemination of the bacilli has taken place, curative treatment is absolutely futile. The most favorable conditions are that treatment be instituted early, and that it be prosecuted actively and energetically during a prolonged period.

15. The surgical treatment of leprous sores, necrosed bones, perforating ulcers, the excision of tubercles, amputation of the members, tracheotomy, various delicate operations about the eye, nerve-stretching for the relief of pain, the removal of threatening complications, are of the most signal benefit.

16. Finally, we may conclude that while medical science holds out no definite promise of cure to the leper, its resources are sufficient to arrest or retard the progress of his disease, to promote his comfort, and to prolong his life.

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See Publishers' Department, Page 396.

BALTIMORE, SEPTEMBER 1, 1894.

Abortion.

THERE can be no doubt of the fact that abortions are much more frequent than in former years. The cause is due to the unwillingness upon the part of many women to undergo the responsibilities of childbearing and of motherhood. Various methods are employed to provoke the uterus to expel its contents. It is not necessary to enumerate them, since they are familiar to observing practitioners. The evil results of this fraud upon nature are so widespreading that an earnest protest should be raised by every physician against the practices employed by man and wife to defeat the purpose of nature. We see no way of reaching this moral and social evil except by detailing the dangerous consequences which so often follow the premature death and expulsion of the fetus.

It would be safe to assert that over 60 per cent. of the diseases of the uterus, tubes and ovaries can be traced to the influence of abortion. Subinvolution, salpingitis, pustubes and pelvic peritonitis are some of the remote results of abortion, whilst sepsis, peritonitis and fatal hemorrhage are among the immediate results which speedily destroy life or bring about a condition of permanent invalidism.

Abortion results from two chief causes. First, diseased conditions of the uterus or of the fetus which pave the way to premature expulsion, and, second, to violent measures, either voluntary or accidental, which destroy fetal life and provoke the uterus to expel its contents. Drastic drugs are not infrequently taken to produce this effect, whilst mechanical measures of every device are employed to provoke uterine pains or to bring about a violent separation.

Among the first causes, the responsibility of the mother can not be called into question. She is often the innocent sufferer. Fortunately for such women nature is conservative in paving the way for the expulsion of the fetus and its secundines. Both are usually expelled without serious danger to life, and if ordinary care is exercised neither hemorrhage, sepsis nor subinvolution are observed. With the second class the result is far different in proportion to the violence of the measures employed to induce the abortion. Neither uterine nor fetal disease has brought about those degenerative changes which lead to an easy separation of the fetus. On the contrary, violence has been employed and a dead fetus is thrown out of a healthy pregnant uterus not previously prepared for the vascular disturbances which ensue. The placenta if fully formed is instantly torn from its attachment. The interruption of the processes which have been set in motion by pregnancy is a violent shock to the entire female economy and a train of results may ensue which will leave the reproductive organs permanently damaged.

But view an abortion from whatever standpoint we will it is a condition to be treated with extreme care. A dead fetus *in utero* is an abnormal product. It is, strictly speaking, a foreign body which must be removed. In the majority of cases the uterus can be relied on to expel its own contents and the physician becomes the servant of nature to assist in this function when necessary. We know of no condition which requires such good judgment as to know when and when not to interfere in these cases.

A careful study of the case will usually sug-

gest an intelligent line of action. Hemorrhage is the first symptom to occasion alarm as a rule. This may be controlled by the temporary use of the tampon and next by dilating the cervix and promptly removing the fetus and its secundines. Sepsis is more to be feared than hemorrhage, since it is a concealed influence undermining the vital forces before its symptoms are apparent. A sudden rise of temperature should arouse immediate suspicion. But sepsis may be in full force without any such prominent suggestion. A normal or subnormal temperature with quick, feeble, wiry pulse, clammy condition of the skin and an anxious mental condition will be observed as premonitory symptoms of infection. Under such circumstances the physician should be prompt to act. The uterus should be curetted and made thoroughly aseptic at once. Prompt attention to these cases of abortion will safely tide them over critical conditions ; but inattention, delay and neglect may impose upon the patient a condition of the uterus, tubes and pelvic tissues which will permanently injure the health of the woman. Whatever work is done within the vagina or uterus should be thoroughly aseptic. The curette in careful and experienced hands is simply invaluable in the treatment of these cases. The finger cannot always be made to reach the entire uterine cavity. Its usefulness is limited. But whatever agency the physician employs his chief reliance must be in thorough and careful cleaning out of the uterus and subsequent cleanliness and asepsis.

* * *

Fatal Epidemics.

An exchange asserts that reports of death from fatal epidemic diseases abroad exist only in the imagination of the reporters and that there is much exaggeration. It is hard to reconcile this statement with the official reports that come in monthly from all places where statistics are kept. For instance, in the city of St. Petersburg from July 22 to August 1, there were 1046 cases of cholera registered and of these 620 died. On August 1 there were still 451 cases under treatment and the disease is not confined to the *bourgeoisie* or citizen class but many cases are occurring among those in the higher walks of life. In Liège in Belgium cholera is not only undoubtedly present but it is spreading rapidly. While cholera has made little headway in China, the plague still continues there and estimates of total plague deaths in Canton since March 1, 1894, vary from 50,000 to 100,000. The most reliable statistics are based on reports of coffin-makers. Only a few of the plague patients in Canton or Hong Kong recover or are discharged as cured. Scarcely five per cent. of those attacked recover. Neither native nor foreign doctors seem to know what to do with plague cases.

* * *

Anti-Toxines in Diphtheria.

It is very gratifying to notice how much more accurate are the press reports of new discoveries in medicine than formerly. A Sunday paper gives *in extenso* the anti-toxine treatment of diphtheria as practiced in Europe and the report is exceptionally good. If time and experience in skilled hands show that the anti-toxine treatment of this disease is one-tenth as successful as enthusiastic reports would have us believe then that dreaded disease diphtheria will soon lose its reputation as a most fatal malady and deaths from it will be exceptional. Discoveries of such kinds should not be announced until long experience in reliable hands has shown their true value.

* * *

Diseases in Season.

The summer has come to an end and the first day of a new season opens. In looking back over the three warm months of the year it is gratifying to note that the infant mortality has not been as great as in former years and the little ones will now have a chance to eat and sleep without that danger of wasting away, worn out by the various intestinal diseases. Still each season brings its dangers and if the infants may thrive now, those who have diseases of the respiratory apparatus or a tendency thereto will begin to feel their troubles as the changeable weather comes on. Then, at this season, schools open and families return to houses that have long been closed, and unless rooms are thoroughly aired and defects in plumbing work which may have occurred in the summer be remedied, disease may spring up where it could have been prevented.

MEDICAL ITEMS.

Vienna has a Pasteur Institute.

The British Institute of Hygiene held a very successful meeting last month.

The next meeting of the British Medical Association will be held in London.

Dr. Christopher Johnston, Jr., is recovering from a severe attack of malarial fever.

A German crank has founded a society whose members eat fruit only and no cooked food.

Dr. William Osler advocates a meeting of the British Medical Association at Montreal, Canada.

According to the new tariff act, alcohol to be used in the arts and for medicinal purposes is admitted free of duty.

Professor Langley of Washington, D. C., has received the degree of D. C. L. *honoris causa* from Oxford University, England.

The twentieth annual meeting of the Mississippi Valley Medical Association will occur in Hot Springs, Ark., November 20, 21, 22 and 23, 1894.

There are about ten thousand opium smokers in New York, according to the testimony of one of the witnesses before the Lexow Committee.

The Lehigh Valley Medical Magazine, which has heretofore been issued as a quarterly, will appear bi-monthly until April and then once a month.

Dr. Charles A. Wells of Hyattsville, Maryland, is spoken of as a probable nominee to fill the unexpired term of Hon. Barnes Compton in Congress.

A physician in England sued a patient for slanderous statements, gained his case and was awarded damages. This is a reversal of the usual result.

Professor Stellwag, the distinguished Professor of Ophthalmology in the University of Vienna, has resigned his chair, having reached his seventieth year.

The Duke of Westminster will not let any of his houses in the West End of London to physicians for fear they will drive away his fashionable tenants.

The death of Dr. D. Clinton Morgan, whose illness was announced last week, is reported. Dr. Morgan was a retired physician who followed mercantile pursuits.

Dr. J. J. Kinyoun, Surgeon U. S. A., has been ordered to Buda-Pesth to represent the United States Marine Hospital Service at the International Congress of Hygiene and Demography.

The beautiful Lake Windermere in England, with all its charms of poetical associations, is said to be a source of danger from the large amounts of sewage emptied into its limpid waters.

The *New York Medical Times* says that in Sweden ten years of study are required of medical students and so careful are they to have men advanced in this science that homeopathy is forbidden there.

A quilted cushion containing meshes of fine wire by which any degree of heat may be obtained from an electrical current, is the latest invention. It is called the thennogen and may take the place of hot blankets, hot water bags and such appliances.

Dr. W. C. Dabney, Professor of Obstetrics and Medicine in the University of Virginia, died at Charlottesville, Virginia, about two weeks ago. Dr. Dabney was born in 1849 and was educated at the University of Virginia. He was a great favorite with his pupils.

Harvey F. Getzendanner, A. M., D. D. S., M. D., of Frederick, Maryland, will deliver the Seventh Annual Address before the Boston Gynecological and Obstetrical Society to be held at Boston, Massachusetts, Wednesday, October 24, 1894. The subject will be "The Early History of Midwifery." Dr. Getzendanner is writing a work on Diseases of Women, which will be ready for publication about January 1, 1895.

Among the members registered at the Bristol meeting of the British Medical Association was Dr. William Osler of Baltimore and among the guests were Drs. W. E. Ashton, Philadelphia; H. D. Chapin, M. D., New York; Geo. M. Gould, M. D., Philadelphia; James B. Herrick, M. D., Chicago; Herman Knapp, M. D., New York; W. P. Northrup, New York; Samuel D. Risley, M. D., Philadelphia; Paul J. Sartain, Philadelphia; G. C. Savage, M. D., Nashville; G. E. de Schweinitz, M. D., Philadelphia; and Dr. Geo. T. Stevens, New York.

BOOK REVIEWS.

INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY. Authors and Subjects. Vol. XV., Universidad—Vzoroff. Quarto. pp. 842. Washington: Government Printing Office. 1894.

It is very gratifying to note how near to completion this magnificent work has reached. This volume, which is not quite so large as some of the others, includes 6152 authors' titles, representing 3312 volumes and 4235 pamphlets; it also includes 8596 subject titles or separate books and 35,667 titles of articles and periodicals. In glancing through this work, the first important subject noticed is "Universities," which takes up a number of pages. As would be supposed, the subject occupying most space in this volume is "Uterus," which covers 220 pages, not including "Uterus-cervix," which takes up about 20 more, while "Urethra" covers but 53 pages and "Vagina" but 20.

REPRINTS, ETC., RECEIVED.

Medico-Chirurgical College of Philadelphia, Announcement 1894-95.

Fourteenth Annual Announcement Toledo Medical College. Session of 1894-95.

An Operating Table. By Hunter Robb, M. D. Reprint from *The Johns Hopkins Hospital Bulletin.*

Functional Dyspepsia, So-Called. By R. C. M. Page, M. D. Reprint from *The New York Polyclinic.*

Asepsis in Minor Procedures. By Hunter Robb, M. D. Reprint from *The Maryland Medical Journal.*

Alumnol in Dermatology. By L. Abbott Cantrell, M. D. Reprint from *The College and Clinical Record.*

Abdominal Surgery of the Battlefield. By N. Senn, M. D., Ph. D., LL. D. Reprint from *The St. Louis Clinique.*

Can Typhoid Fever be Aborted? By J. E. Woodbridge, M. D. Reprint from *The Journal of the American Medical Association.*

Notes on Gynecological Technique. By Hunter Robb, M. D. Reprint from *The New York Journal of Gynecology and Obstetrics.*

University of Maryland. Eighty-eighth Annual Announcement of the School of Medicine, Baltimore, Maryland. Session 1894-95.

CURRENT EDITORIAL COMMENT.

THE IDEAL DOCTOR.

The American Practitioner and News.

WE have known in our own brief time some doctors whose lives have approximated, in zeal and sincerity of purpose, that of Sir Andrew Clark; but, alas! their number is not now on the increase.

THE GOLDEN MEAN.

Columbus Medical Journal.

THE physician must preserve a golden mean between his duties and his pleasures; must mingle with his patients socially without losing his dignity as their counsellor; he must command respect as well as admiration. To maintain dignified assurance, without falling into the vauntings of a boaster, constitutes the supreme talent of a physician.

THE DANGERS OF MILK.

Modern Medicine.

EVERY mother who is feeding a young infant with cow's milk should be supplied with litmus paper, by which the acidity of the milk may be tested, so that she may know when the food administered is of a character more likely to result in disease than in healthy nutrition. The perils to which infants fed upon cow's milk are almost universally exposed, is evidenced by the great fatality which attends the artificial feeding of young children.

THE RENEWAL OF PRESCRIPTIONS.

Medical News.

COUNTER-PRESCRIBING, nostrum-dispensing and indiscriminate renewal of prescriptions are evils of which the pharmaceutical profession were well rid, but the failure to observe the explicit instructions of the prescriber would be a breach of faith that could not be condoned and would not be tolerated. With equal right the druggist might in his judgment change the proportions, or the quantities of the ingredients, or even the ingredients themselves. We can scarcely believe, however, that there is any considerable number of pharmacists who would prove themselves so unworthy of confidence as to fail in the matter of prescriptions to comply with any legitimate request on the part of the physician, and surely the desire to control the treatment of a patient for whose welfare he assumes the responsibility cannot be considered as otherwise than legitimate.

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NOTES.

DERMATOL is said to be a good and safe drug in diarrhea.

*

LIME water taken internally is said to cure an attack of furunculosis promptly.

*

QUEBRACHO is an effective, but not much used remedy, in asthma and chronic bronchitis.

*

VINEGAR used locally in uterine hemorrhage is effective and easily obtained in an emergency.

*

APPLY twice a day for a week or more pyroligneous acid, commonly called oil of smoke, to cure ringworm.

*

COLOCYNTH in the constipation of gout, and podophyllin in old cases of syphilis, both give good results.

*

BROMIDE of potassium dissolved in glycerine and water is said to act well as a local application in hemorrhoids.

*

ENGLISH physicians have just found out that the American wild cherry or prunus virginiana is an excellent heart tonic.

*

THE fluid extract of conium, made from the leaves, given in doses of 15 or 20 drops three times a day, gradually increased to 60 drops, if necessary, is highly recommended in torticollis.

READING NOTICES.

"*Paraldehyd*" possesses many of the good without the evil qualities of chloral, used in insomnia resulting from various causes. The objectionable taste of the chemical is, to a great extent, disguised in Robinson's Elixir Paraldehyd which is an elegant preparation.

*

Pinus Canadensis.—A. R. de Escarra, M. D., Paris, France, says: With S. H. Kennedy's Extract of Pinus Canadensis the results have exceeded my expectations. In three cases of metritis, accompanied by abundant and very viscous secretions, I was able to note the improvement almost at a glance.

*

Hæmoferrum is especially valuable in treating cases of anæmia and chlorosis where the blood is deficient in iron. Messrs. Stearns & Co. will take pleasure in mailing samples of the preparation, with full descriptive literature, to all physicians who are interested, and on receipt of ten cents will forward a full sized package containing 100 pilloids, a quantity sufficient for a thorough clinical test. Write them.

*

Listerine.—In cutaneous disorders, this antiseptic adhesive ointment protects the surface of the wound and is of especial service in dressing wounds of the face, and valuable in cutaneous eruption, excoriation and ulceration:

℞.—Zinci Oxidi . . grs. v
Zinci Chloridi . . grs. xx
Gelatinæ . . . . ℥vi
Listerine . . . . ℥vii *M.*

The gelatine to be dissolved in the Listerine by aid of gentle heat.

*

Papine.—J. H. Brierley, M. D., A. B., of Cumberland, Iowa, says: Papine is a perfect anodyne. One old lady said she had not had one fair night's rest, because of chronic rheumatism, for three months. Papine, one teaspoonful, gave a good night's rest, with no nausea, nor dull feeling next day. I have given Papine to patients who knew they could not take morphia, and they never had a symptom to make them think any preparation of opium had been taken. Wherever morphia is indicated, Papine is much more so. I gave Papine to a patient with periositis with deep abscess, and gave the Papine daily for two weeks without, so far as I could see, impairing appetite or deranging stomach or bowels in the least.

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ORIGINAL ARTICLES.

MASSAGE METHODS FOR THE RELIEF OF TINNITUS AND THE IMPROVEMENT OF HEARING.

Read Before the Medical Society of the State of Pennsylvania.

By Louis J. Lautenbach, M. D., Ph. D.,

Surgeon to the Pennsylvania Eye and Ear Infirmary; Nose and Throat Surgeon to the Odd Fellows' Home; etc.; Late Chief of Eye Clinic of the German Hospital, Philadelphia.

Contrary to the belief formerly prevalent, hearing is not, to any great extent, dependent upon the integrity of the membrana tympani, but rather upon the preservation of the chain of bones with the retention of their normal motion. It is now known that, not only may the membrane be perforated, but even extensively destroyed, provided the chain of bones be intact and in perfect adaptation, the hearing will be but little impaired. In 1883 I treated a case of long-standing suppuration with extensive granulations; upon the careful and complete removal of the granulations and the subsequent treatment of the middle ear inflammation, I succeeded in retaining intact Shrapnell's membrane and the chain of bones. The hearing became perfect for metallic sounds as well as for the voice. The patient is now enjoying normal hearing.

Now, if it be true that, the auditory nerve being intact, and the external meatus clear, the hearing depends upon the natural mobility of the ossicles, we can then consider the membrane as but the outer fixation point for these bones, and as a protector for the middle ear cavity. I do not mean to deny that it may, to a slight extent, serve to concentrate the sound—the shape of the membrane suggests this. Seeing the necessity for perfect freedom of motion in this conducting apparatus, we can readily understand the importance of preventing any attachments to these bones, or between them, or effusions upon them. Effusions, even if unattended by the formation of attachments, may occasion overweighing of some one of them, and thus interfere with the proper conduction of sound.

Unfortunately, however, despite all precautions, effusions and attachments often occur, and it is in these cases that the massage instruments, of which I wish to speak, are appropriate. Some of these may be called *phono-massage* instruments, as they convey sounds through the meatus, membrane and ossicles to the internal ear. Others are for the creation of *pneumo-massage*, no sound being conducted, but producing a to and fro motion of the membrane and ossicles. Others, again, may be termed *mixed massage* appliances, as they transmit sound vibrations, and, in addition to this, effect a mechanical massage of the membrane and ossicles, independently of the sound.

It is these cases which have baffled the best endeavors of the most skillful otologists, and to relieve which numberless treatments and operations have been devised, even to the multiple perforation

or destruction of a large part of the membrane, or its removal or the removal of one or more of the ossicles to which the massage methods are applicable.

The cases, unfortunately, have not been infrequent where loss of hearing and tinnitus, due to hyperemia and catarrh of the middle ear, have resisted all our efforts.

We have all been seeking for better methods, so as to increase our percentage of cures, and the consequence has been that since 1886, when Sexton published the results of his excision operations, there have been many followers, and yet how disappointing have been the results. Personally, I have performed excision, with the removal of one or more ossicles, but 23 times, and I intend in the future to perform it only in such cases as, where after prolonged and careful treatment, I fail to relieve distressing tinnitus, or where the hearing, after all has been done that is possible, is such a bar to the patient's comfort and peace of mind, that it is demanded as a last resort.

In other words, conservative medicine is to be given a thorough trial, and only after such trial is the operation to be done. Before such an operation is legitimately considered, the question necessarily arises as to whether or not either pneumo-massage or a combination of both will prove of benefit; of course, the Politzer and Valsalvan methods may be considered as massage methods. But it is not of these agents, which operate through the Eustachian tube, but rather those which exert their influence by increasing and diminishing pressure on the membrana tympani through the external meatus, that I propose to speak.

By remembering the value of massage in other parts of the body, we can readily understand its effects upon the ossicles. The movement of the joints brings to that region an increased circulation. It breaks up adhesions directly by motion, and occasions absorption by the increased circulation; in addition to toning up the muscles, not only by a stimulation of the nerve fibres and their endings, but by the increased blood supply. It exercises the tensor tympani, restores this muscle to normal function, brings a healthy, active circulation to the membrane; this causes absorption of fibrous tissue which is broken down through the mechanical movements; stimulates the mucous membrane of the middle ear to healthy action, and probably by the same process, restores some of the lost elasticity to the round window. Besides this, a condition which is unexpected, but is proven by experience, is the opening of the Eustachian tube, which has, perhaps, been closed for weeks or months. I do not pretend to say that massage will relieve diseased conditions of the auditory nerve, but we know that normal stimuli are of value to all nerve endings in continuing or restoring their functions.

It can be readily understood that in the choice of phono-massage instruments care must be taken, when the internal ear is affected, to use only such instruments as will not prove harmful to the nerve, but, if possible, prove of advantage. This may readily be accomplished if sufficient care be exercised to thoroughly study the case. I am sure, if this be done, not only will the conducting parts have restored to them much of their function, but the internal ear will be roused from its frequently dormant condition and become again a proper recording medium.

Simple or pneumo-massage (without sound) instruments have on the internal ear no effect but that produced by the motion of the stirrup in the oval window, and the transmitted motion on the round window, occasioning increased circulation as well as a more active movement of the fluids of the internal ear, but will have no direct effect on the nerve endings. The phono- and mixed-massage instruments accomplish this.

The first scientific instrument to accomplish massage of the membrane was the Sieglé speculum, or otoscope, which consists of an ear speculum, the opening of which is closed by a glass plate, and connected with the body of the speculum is a tube with a mouthpiece, the whole being air-tight when the speculum is inserted. By means of the mouthpiece, the air in the external meatus is condensed and rarefied, and thus movements

of the membrane and ossicles are produced.

Delstanche later made use of another instrument called the "masseur," which consisted of a small air-pump worked by the finger.

Sexton, in 1884, advised the use of the double ear tubes, as a method for the more thorough education of those affected with defective hearing, apparently unconscious of the fact that he was on the threshold of an important discovery. It is of this conversation tube that Spear said "It was invaluable to stimulate the auditory nerve whose functions have become impaired by disuse."

Maloney, in 1887, invented the otophone, which is a speaking-tube closed at the one end by a diaphragm. He used it not only as an ear-trumpet, but also to improve the hearing.

In 1892, Garey commenced to use a string instrument, the vibrometer, the sounds made by the vibrations of the strings of a banjo being conducted to the ears. The instrument now consists of four strings stretched over a banjo frame. The strings are set in vibration by a pronged wheel which, revolving over them, picks the strings—the sound being carried to the ear by double ear tubes. One string can be played on or two strings can be set in vibration at once. In addition to this, the instrument is provided with a suction apparatus, the double ear tubes connecting with this, you are supposed to have simple massage, but considerable sound is also carried.

The vibrophone is an instrument, the purpose of which is to carry to the ear the sound of the opening and closing of an electric circuit, as well as to produce a distinct change of pressure on the membrana tympani. As originally constructed, it carried sound only, but has been modified as above at my suggestion.

The old mechanical methods of applying massage by the hand produced good effects, but were crude. Cleland's and Moos's methods labor under the same disadvantage. The Sieglé speculum, the rarefacteur, and masseur are all of value, but they cannot be continued as long as many cases demand, nor can they be as carefully regulated. Sexton's conversation tubes are of value, as is likewise Maloney's otophone, but they are conductors of sound and sound vibrations, and while they independently of this yet produce massage of the membrane and ossicles, this is not capable of exact regulation. Neither the vibrometer nor the vibrophone gives massage without sound, although the vibrometer is supposed to do so.

In many ear cases, the nerve is exhausted. In mill workers and boiler makers, the ear nerves are over-stimulated and later become exhausted. In treating such cases, or again in treating cases of hyperesthesia of the nerve, as little sound as possible should be transmitted thereto for fear of occasioning further damage. In these cases it is necessary to have silent machines; or rather, such as will produce to and fro movements of the membrane regularly, with little or no sound. This I originally accomplished by means of an induction coil having a slow and fast vibrator, each capable of regulation; and connecting with this, an air-tight telephone with double ear tubes: each make and break of the current occasioning a motion of the membrane.

Some two months ago, I began to use a metronome to make and break the current, and find it better in every respect. I have the metronome so wired that each swing of the pendulum makes and breaks the current and acts on the telephone in the way just described. I have called this instrument the *metronomic ear masseur*. With it you can get anywhere between 40 and 200 suction movements of the drum-head per minute, and any amount of motion desired.

For some six weeks I have been using the phonograph, both as a test and as a remedial agent, and consider it the most accurate test I employ. In using the phonograph as a remedial agent, I use voice and instrumental records as well as mechanical ones. This instrument is by far the best phono-massage method, and appears to be specially indicated where we are dealing with cases accompanied by considerable tinnitus.

It is evident that massage will prove

of value in the treatment of diseases of the ears, that it will in many cases obviate the necessity of severe operations and give better results. Unlike these operations, the parts are left intact, so that should massage or other treatment fail, there is still an opportunity for further measures. It may be applied by any one of three methods: 1st. Pneumo-massage. 2d. Phono-massage. 3d. Mixed-massage, being careful, where the internal ear is affected, not to use too violent pneumo-massage, nor too shrill phono-massage, but to apply it most carefully, as otherwise there is danger of labyrinthine hemorrhage.

The time the massage is to be employed varies greatly with the kind employed and the nature of the case, from 2 minutes in acute cases to as much as an hour in chronic ones and from about 1 minute, when the shrill massage is used, to 15 minutes or more, when bass tones or sounds of small volume are used.

Of course, constitutional and local treatment are as necessary when this method is employed as without it, although you will observe among my 153 cases referred to here, some which had been thoroughly treated, and yet failed to improve, steadily improved on the massage treatment alone.

To illustrate the effects of this new treatment, I will give a resumé of my 153 cases so treated. Of this number all improved in hearing or had their tinnitus materially lessened with the exception of 6.

I used the massage treatment on quite a number of my old patients with whom I had failed, and with the exception of 2 improved them all.

On others of my patients I have used massage methods alone with marked benefit.

Another series of cases I put on the regulation nose, throat and ear treatment to which was added the massage treatment, and of these all but 4 cases improved.

Another series of cases (2 only) were deaf-mutes. Both of these have improved in hearing and in speech to a remarkable degree.

Of the six cases which I failed to improve, 2 were cases of hypertrophic catarrh and 4 of atrophic catarrh. I will illustrate the 4 series by a single case of each class.

Class 1. Treated in the past without improvement; by addition of massage, the case improved.

Mr. C. Z., 77 years, treated by me in 1884 for eight months; no marked improvement. He has been affected since 1869. He returned to me, March 27, 1894, membrane very much thickened with lower half adherent to promontory; watch not heard in either ear; conversation not heard, only hears when talked to in ear, and then only with great difficulty; for the past year or two unable to distinguish the piano tones—has been an expert pianist. After daily treatment for 20 days, he informed me that all his friends remarked upon his improved hearing, and that for the past two days he can again enjoy the piano, being able to distinguish the tones.

Class 2.—Treated by massage methods alone with improvement.

Mrs. H. W., 22 years, came February 10, 1894, with a history of catarrhal deafness of one year; ringing and buzzing were frequent; voice hearing impaired, for watch, R. E., 12 inches, L. E., 18 inches. Treated twice a week for 7 weeks; voice hearing good; watch, R. E., 20 inches, L. E., 36 inches; tinnitus disappeared.

Class 3.—Treated by ordinary methods with addition of massage all improved except four.

Mrs. R. W. R., aged 38, came March 5, 1894 (a case in which about two years previously I had given the opinion that I did not think I could improve her hearing). Both membranes had large perforations from scarlatinal otitis suppurativa 37 years ago; had for years noticed a gradual diminution of hearing; voice hearing very poor, watch not heard; tinnitus deep in character. Treatments were given every other day. April 24, 1894, she heard a thunderclap, a sound which she had not heard before for 15 years. May 9, 1894, she heard a dynamite explosion (quarrying) some four miles off. May 17, 1894,

watch, R. E., 8 inches, L. E., 15 inches +; voice hearing fair. Her friends have been so astonished at her markedly improved hearing that I have heard of this case in many quarters.

Class 4.—Two cases of deaf-mutes; both markedly improved.

Miss E. G., came January 28, 1894, with history that when 18 months old she had scarlet fever; that the ears were painful; that the lymphatic glands below ears enlarged and were opened, but that ears did not discharge; that from this time on she heard apparently nothing, but felt violent jars only; that she has endeavored to utter sounds which seem to resemble words; that two unfavorable opinions had been given by specialists on the case. By careful testing, I arrived at the conclusion the auditory nerve endings were at least to some extent sensitive; that, however, it took a powerful sensation to excite them, and that it took a long time for a sound massage to be perceived by them. For a month I used the usual treatment for such cases. On February 28, 1894, I commenced the use of phono-massage and of mixed massage, and later phono-massage was applied twice a week, until now she can readily hear my watch tick, hears the friction cards easily, and the tuning fork annoys her by reason of the intensity of sound. Voice hearing is not good, but she hears a loud voice if words are slowly uttered (sluggishness of perception of auditory nerve), and she has increased her vocabulary from nil to several hundred words, and is able now to converse quite readilly with other children as well as with her parents.

The following *conclusions* are the results of my experience:

1. Poor hearing is usually the result of some want of mobility in the sound-conducting apparatus.

2. This want of mobility can almost always be overcome by the use of massage, especially pneumo-massage applied directly to the membrana tympani or ossicles.

3. That the pneumo-massage is in ordinary cases the most serviceable, phono-massage being especially indicated where there is a necessity for exciting atonic ear nerves.

4. That as the mobility of these parts increases, the hearing improves and the tinnitus disappears.

5. That the results are most favorable in cases of hypertrophic catarrh and in retracted membranes following suppuration; less favorable in the proliferous variety of catarrh, and unfavorable in the atrophic variety and in cases of involvement of the auditory nerve endings.

6. That the treatment will in great part supplant the removal of the ossicles and similar operations.

Operations on Uterus and Ovaries in Pregnancy.—Everke (*British Medical Journal*), in a monograph on some Cesarean sections in his own practice, adds some cases of ovarian and uterine tumors in which operations were undertaken during pregnancy. In two cases he enucleated myomata. The first patient was in the fourth month of pregnancy; the tumor was of the size of two fists. Abortion occurred two hours after the operation. The second was three months' pregnant. The tumor was as big as a child's head; the patient recovered without fever. Four weeks later abortion occurred, during an attack of gastro-enteritis, with high temperature. In both cases the sac left after enucleation was sewn to the abdominal walls. In two cases of ovariotomy the first was pregnant two months, and gestation continued to term; the second, five months pregnant, was spontaneously delivered eight hours after the operation. Both recovered. In two successful cases ovariotomy was undertaken after delivery. On one occasion Everke observed spontaneous reposition of a large ovarian tumor during labor. In one patient in the fourth month of pregnancy a cancerous growth of the size of a crown piece was excised from cervix without abortion ensuing.

MEDICAL LEGISLATION.

THE ANNUAL ORATION DELIVERED BEFORE THE ALUMNI ASSOCIATION OF THE COLLEGE OF PHYSICIANS AND SURGEONS, APRIL 18, 1894.

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[CONTINUED FROM PAGE 383.]

I WOULD that all the people of this wide free land could be gathered into an audience to hear the startling statistics of the mortality tables under the head of zymotic diseases. I would that every mother could realize as she receives her new-born infant in her arms that its happiness and usefulness rest largely on conditions in her own control and that even maternal love sometimes proves a disguised enemy. Nor can maternal love absolve her from blame if she fails, from pride, indolence or ignorance to equip it physically, mentally and morally to cope successfully with the adverse influences that wait upon its advent.

All this is possible, for no man to-day believes in a supernatural destiny, and the best thinkers of every school unite in laying the responsibility of much of the loss and suffering through diphtheria, typhoid fever, through all the gradations of infectious diseases, on incomplete sanitation. Because much has been done, we forget how much remains to be done. It must be remembered that new ideas along the line of preventable diseases are continually brought forward. Diseases already well known change and are modified on account of climatic and social changes going on and so affecting the external and internal atmosphere as to require entirely new treatment. In this respect as in many others we are behind many European countries who have set us the example of activity seconding competent suggestions for the health and protection of the people. True we have a very excellent system of protection already in existence, in our boards of health and the devices proposed by them, but I have found for myself and in the experience of others, that it is often inoperative in the smaller towns, partly from its too general provisions, and partly from want of organized effort. Here is where legislative action might come in, and a more progressive system of inspection inaugurated. Officers might be elected to discharge these duties, just as they are for other positions, and a regular and constant surveillance should be exerted. Even the constructions of our dwellings and public buildings should be made a legitimate object of inspection, and the surrounding premises, the water-supply, etc., on private and public grounds should be as accessible for this purpose as the streets and highways. Absolute authority should be placed in competent hands and no demur should be possible. The men or women—for women are equally fitted for such work and should be equally eligible to positions in the system proposed—should be of known ability and character, and no evasion or neglect of their duties should be permitted under penalty. These duties should include more than an occasional cursory inspection of premises or general surroundings or under necessity, of persons. The civic dignity of any municipality should hold it a sacred demand, that such an officer be an expert, in his department, and, inasmuch as specialization is the gauge of progress in civilization we assert that our sanitary system should be administered throughout by specialists. A knowledge of bacteriology, chemistry, engineering science and mechanical work, all enter into it, and it is the duty of the hour for our profession to demand that special provision

for such an object and special equipment for carrying them into effect should be made ; and so extended in their operations that from the cities of the seaboard to the hamlet in the hills, from the palatial residence of the millionaire to the humble cottage of the laborer, none shall be excluded. The public school system, of which we are justly proud, includes the poorest child in the nation; so wide and all-embracing, so thorough and efficient would we have our national sanitary system. To accomplish these results, special institutions, or special courses in those already in existence might be established, under the fostering care of the government, for such as would desire to devote themselves to the exacting studies required and are not able otherwise to do so. Such service to the State would be as honorable as that pursued in our national naval and military schools.

From the wide range of this division of a subject which the limits of an occasion like this have compressed into a series of suggestions rather than elaborated hypotheses, or sustained arguments, we turn to a different and more specific department of medico-legal effort. It is that of the "defective classes" the insane, feeble minded, epileptic and otherwise mentally abnormal. Notwithstanding the generous provision made by the State for these classes, there yet remain many whom such a provision does not reach, either because of a lack of knowledge of its full import or because it does not cover the particular case—sometimes also from a distorted sentiment of personal affection. From these and other causes a large class who are unfitted for the duties of life and should for all reasons be under professional surveillance and care, if treatment is not available, are left to buffet the world, and endure the ill usage which they are likely to receive. There are very few physicians, especially in the smaller towns and outlying districts, who fail to encounter such cases in their practice whose helpless state appeals to their warmest sympathies. From a feeling of pride or an affectionate reluctance to see them go beyond their personal care, families too often retain such members in semi-confinement, or perhaps in a dangerous liberty, neglected and not seldom ill-treated, when, if properly cared for, they might be at least measurably restored, or if beyond that, suitably placed where they would receive the alleviations now so humanely provided. Especially in the case of the young does such a rule apply. To my mind there is no sadder sight than a child otherwise in full health but with a clouded intellect. It may be that it itself is partially conscious of its condition, and as it sits apart silent and moody, or mingles as if on sufferance with its companions, the deepest sentiments of pity must be stirred in its behalf. Americans are ever averse to compulsion in the realm of individual right, but in such a case there should be no question of its application. All such children should be noted and reported by the physician or other official holding the power to do so, and whether willing or not should be placed in an institution adapted to its needs, and where its blighted powers might develop.

For epileptics especially, such authority should be exercised, as with the advances of surgical science many may be brought back to a normal mental condition. Great strides will be made in the next ten years toward a better understanding of this class and their disabilities. When such men as Keen of my own State and others of national repute enter upon a line of investigation with the ardor and enthusiasm evinced in their late experiments, it is safe to predict definitely useful results.

The slighest allusion can only here be made to the vast importance of a careful supervision of the insane who are at large. It is forcibly enough brought home, to society, when in a fit of ungovernable passion a crime is committed by one who is adjudged irresponsible when too late. Marriage and the certainty of transmitting the eccentricity or lesion, as the case may be, should be prohibited among all classes suffering from mental deficiency. Many States already have laws prohibiting marriage within the limits of consanguinity and

all should have. Free discussion of the subject before the public should be encouraged, for in all such matters public sentiment can be trusted.

Behind these defective classes spreads the wide field of cause and effect, and it is here that we may have hope for success in our efforts to prevent the further increase of insanity. Probably the most fertile cause of this increase is the excessive strain put upon the brain by our educational methods at an age when the structures are too delicate to bear it. Defective illumination and ventilation, the protracted confinement, the exacted night work, and the subjection of natural attitudes to a rigid angularity of posture tend to the impairment of the general health and the nervous system breaks down, the subject becomes harassed, loses the power of concentration, and if it is of an emotional or sympathetic temperament is likely to fall into an acute attack of nervous disorder and never regains its former powers. Sometimes a state of dullness and semi-idiocy supervenes. The effects of the injury, however incurred, become permanent, and a wrecked life is the consequence. One cause for the appalling increase of insanity among adults is the stress of competitive business, consequent upon our financial methods. It is impossible to discuss here the varying effects upon the brain of this constant strain, perhaps at a time of life when nature craves repose ; it is enough to name it as one of the most potent sources of harm. Our manner of living may also be cited in this connection. The desire for social prestige is second only to the ambition of pecuniary independence. Other causes readily suggest themselves to every observing man, but the truth is, they all fail to account satisfactorily for the doom which seems to be hanging over our coming generations in this respect. Conjecture takes the place of knowledge and we are left to speculate on the cause while we go on multiplying extensive and expensive asylums for those so afflicted. If legislation can apply a remedy it should not be withheld for a single moment. Manufacturers who employ child-labor should be carefully watched; amusement and judicious exercise should be provided for the poorer classes who cannot supply the want themselves.

From actual insanity as it exists in the abstract to crime, pauperism, and other forms of moral degradation is only a short step, and the question of social purity unrolls itself before us, like a vast scroll whereon each one can inscribe his name in letters of light, or mark it in characters of condemnation. The world moves. A few years ago no public speaker would have ventured to touch upon such a subject or attempted to delineate the consequences of a habitual disregard of what we call morality. But to-day these subjects may not only be mentioned but they are engaging the attention of able and philanthropic men and women throughout the land. To seek for the cause of disease, to work for the prevention of crime, has been the aim of the wise of all generations, but it has been reserved for these later years to find a partial solution of many of these vexing problems, perplexing alike to the political economist, the moralist and the man of science. The fact is being recognized as never before that mental and moral blight, and the destitution, suffering and social disorder growing out of them, are often the result of immorality transmitted through lines of inheritance. The sins of heredity are hopeless of remedy or repentance. The impelling tendency and cowering will are fundamental, and conscience cannot be reckoned upon in a life mostly made up of lapses from rectitude. Lawmakers have apparently ignored the fact that this physical taint is the underlying cause in a large per cent. of the defective classes, paupers and low grade criminals, and that all charitable and religious inquiry is futile, when confronted by this controlling degeneration. Other infectious and contaminating centers have been met and fenced in, to some extent at least, but here has been left a source of danger more fatal in its effects than any plague that ever depopulated a city. We might as well expect to purify a house by pouring into it the most powerful germicides, while the

cellar was full of rottenness, as to rescue a soul from the grip of a body in the throes of moral dissolution. More binding than any obligation is the one we owe our descendants, and it would be infinitely better to open every avenue of foulness and decay, and let the death-dealing poison do its work, than that we should send our children forth into a world bereft of its highest ideal.

Enlightenment on these subjects must come, and come through the physician, for he alone will gain hearing and credence. After that the task will be easy to obtain laws depriving these classes of the power of menacing the safety and happiness of those who come in contact with them, and of perpetuating their disabilities.

If the State has a right to take into its custody one citizen because he has a disease which is dangerous to other members of the community, it has certainly the right to take another into its custody whose whole moral fiber and physical being has been hopelessly disintegrated by an experience of vice covering the most of his life—or an inheritance of weakness which the mercy of God may pity but cannot remedy. I hold, and an examination of the subject will bear me out, that greater havoc to the public weal is wrought from this cause than from any war that has ever swept the face of the earth—or any pestilence that temporarily paralyzed the centers of population. It is the upas-poison that saps the bases of the social structure, making rogues and scoundrels of men because will and conscience have collapsed and they become the prey of temptation.

Realizing the gravity of these dangers, it is inconceivable how apathetic public opinion remains, and how few of those who adopt the role of reformer attempt to point out its significance. The clergy with small exception are silent—rather occupying the minds of their hearers by learned disquisitions on worn-out dogmas and polemical questions which are of no practical benefit; and which the world has mostly outgrown, while they treat in the most remote and fastidious fashion the festering evils of which they may well be cognizant but which they fear to touch. Let the clergy from their place of vantage thunder forth the axiom uttered centuries ago, and holding just as true to-day: "The sins of the fathers are visited upon the children." They need not go far for illustrations of its force. And the educator, he who perhaps more than any other has to do with the individual in the character-forming period when,

> "The mind impressible and soft with ease
> Imbibes, and copies whatso'er it sees,"

let him make it as impressive as a law of mathematics the certainty of the penalty following the offence, against right-living, temperance and purity. We have the witness of our own senses in proof of these statements. We cannot walk the streets without meeting those who, to the practiced eye, bear the marks of dissolute living. Not all in the garb of the beggar to whom in pity we toss an alms—not all among those who are objects of scrutiny and interest to the police, and who eventually turn up in the felon's dock. Not these only, but clad in "purple and fine linen," among the "genteel," the well-to-do, the cultivated classes, we find them victims or transgressors, or both, the weakened product of a tainted ancestry, or the progenitors of a fore-doomed generation, each one endowed with a power for harm impossible to exaggerate.

Upon these subjects great ignorance prevails. Outside of professional circles, few know how the vices of one generation become the nemesis of the next and thus neutralize the advanced environment and advantage of era. Few understand that an inherited tendency in the mental and physical structure is as influential and persistent in transmission as the color of the eyes and hair, and on this theory can be predicted our surest results in reform. The power of hededity acts in an ever-increasing ratio unless it is checked at its source. Many of the inmates of our overcrowded insane hospitals are those who ten or twenty years ago were living dissolute lives and have broken down, lost their self control, and become a charge to the State. The institutions for imbecile

and feeble-minded children derive the large proportion of their inmates from the same contaminated source. Reformatories and other institutions for the restraint of the morally deteriorated, add their quota to those of varying grades farther along or still at large. The superintendents of these institutions, and others whose work lies among the criminal and depraved classes, invariably say that nine-tenths of the crime, pauperism and insanity brought under their notice are in large degree preventable and the tax of their sustenance could be avoided if proper legal enactments were made. Strangely blind has been the policy of the government. To check this ever-increasing burden upon the State, as well as to secure a better race-product, there is but one way, viz. : to invoke the power of the law.

The law naturally follows in the wake of public opinion, and thererefore just as fast as we can educate a wholesome public sentiment on these subjects we can have the restraining force put in action.

Adequate legislation, however, in this more than in any other direction, would meet with many obstacles ; for it would be far from easy so to awaken the public mind as to make the requisite protection available. Such laws would inevitably touch some in high places. The penalty hinted at might, nay, most certainly would, bow with grief or blight with shame, many a loved and honored head. They could be only applicable in the case of those who receive the benefactions of the State, or have made themselves amenable to criminal law. Such legislation as would absolutely purify society in the course of a few generations is only possible in the Utopia of the dreamer. But the hopelessly dissolute—the barnacles of society —could be reached. They should be dealt with as criminals, or isolated as the victim of leprosy. There is no question as to the right of a community to exact so much exemption from the burden of their presence—so much cleansing of the moral atmosphere as would follow from their seclusion. The immediate benefits would be in the heightened self-respect of those with whom they were connected by ties of blood, who would be freed from the disgrace of association, in the prevention of contamination by example or contact, and in utilization of their labor by the State under an organized system of employment similar to our penal institutions.

The law as at present is inconsistent. We constantly see the man who in a moment of passion or under the stinging sense of injury takes the life of another, immured within prison walls for life ; or executed to appease the demands of reparative justice ; and for less grave offences, men are sentenced to the forfeiture of their citizenship, and the odium of convicted felony, regardless of the fact, that in their social and public relations they have been upright and useful, save in the one wrong act for which they are made to bear penalty. The defaulting bank treasurer or clerk has taken money out of our pockets, but his life as a whole has been fair and his influence helpful in the community. Yet, for these we have no word of extenuation or sympathy. We rejoice that justice, though it halts, is mostly sure, and that if he is overtaken he will be punished for his wrongdoings.

But the dissolute person, the feeder of our drinking dens and of other dens more iniquitous still, not only is he absolutely worthless himself, but he robs the community of that which is far more precious than the treasures of the earth, viz.: health and character. And yet, as a general thing, unless he commits an openly flagrant act, he is let alone to spread his baleful influence abroad as he chooses, until outraged nature succumbs and he takes himself or is taken to the doors of our charitable institutions, sometimes to the exclusion of the worthy poor. There he receives the best professional skill and the most faithful nursing to the end that he may repeat his former experience, or failing recovery, die in peace.

I have avoided quoting statistics, as they are but dull arguments in a general address, but every statement made on this topic can be so verified. What

then is the duty which we as a representative body specially interested in the promotion of a high morality have before us ? What relation do we sustain toward these lives, the charge of the State and a menace to its honor ? Is it not to demand by virtue of our self-imposed mission, more effective aid from our natural ally the law ? Then only can we hope in some degree to control the prejudicial forces to which we have here alluded.

Finally, if the physician faithfully discharges these multifarious duties toward society, the State, the individual, there is still one remaining duty, that which he owes to himself, not as a public benefactor or as the preserver of public morals, but with respect to his professional standards. Legislation has paid him the attention of dictating some of these standards, and of indicating its friendly attitude toward his vocation. It has enlarged his facilities for observation, to a limited extent, and has laid a premium upon special and more thorough education, both in preliminary departments and in the medical colleges. The effect of this is seen in the required registration, regular graduation and in some States of special examination by a board appointed by the Governor of the State. It is an open question whether the last has been a gain. In fact it is a real grievance to be compelled to appear before such a board, after taking a full course at an accredited institution, when some of the members have not themselves enjoyed such benefits. But this only illustrates the blunders liable to be made by law-makers, who aim to cover particular conditions by a general provision. Such a law does not solely relate to the profession, for it is primarily designed to be useful to the public. The public, however, is proverbially ungrateful and it is more than probable that the faith-healer and his tribe will flourish as of yore, unchecked by any consideration, legal or illegal. It is in this as in all else upon which we have touched. The physician himself has most concern for the honor of his calling. It is *he* and not the *public* who offers most often the prizes to worthy students in the medical colleges. It is he who is evermost ready to stimulate research though it should lead to the obliteration of his own landmarks, and it is he who is readiest to hold open councils among his brethren and the public on all subjects relating to their welfare. From the time of Hippocrates it has been deemed ignoble to withold from another any special remedy or the fruit of personal investigation. This ideal standard has been regarded in every "code of medical ethics" ever framed, and if the law would support the spirit of these articles, the horde of medical jugglers, and dealers in nostrums, would soon cease to vex the land.

The press, so potent in everything else, ought to see in these indications a source of inspiration for the quickening and perfecting of much that falls within its own department. It must be conceded that in all such questions affecting the general good, in public and private enterprises, and far-reaching influence, the press is superior in facilities and supreme in power. Could we invoke this power to the exclusion of contemptible advertisements, designed to allure the ignorant, and could we gain the ear of the public through this mighty engine, the improvements we have suggested would soon become actual facts.

Gentlemen, as I began with an apology, so I must end ; I feel that I have not done justice to the important subject of wise medical legislation. Its bearings are too wide for the concise treatment necessary in a general address, but I hope that it will receive fuller attention in the future from such among you as perceive its possibilities and who are able to appropriate them. It is in this direction as I believe that hope lies. It is in this way that as in many former instances in the history of human progress that our honored profession would become the highest dependence "of those laborious pioneers who point the scope of elemental right and on a secret anvil hour by hour unforge the fetters of humanity."

MEDICAL PROGRESS.

PIPERAZINE IN NEPHRITIC COLIC.—Of late authors have written much extolling the value of piperazine in certain conditions. Dr. John McKinlock contributes an article to the *New York Medical Journal* showing the efficacy of piperazine in renal colic. The results are certainly well made, but the great cost of this drug will be an objection to its too constant use. The deductions from its use are as follows :

1. Piperazine dissolves concretions not only of uric acid but also of phosphates, etc., in consequence of its power of disintegrating the mucus or albuminoid cementing material which binds them together.

2. Piperazine relieves renal colic and other local pain associated with the formation of concretions in the urinary tract, owing to its power of dissolving the sharp edges of calculi and giving them a slippery character.

3. As a consequence of the effect indicated above, piperazine determines the evacuation of "stones" from the kidneys, ureters, or bladder very soon after administration and before time has elapsed for complete solution.

4. Piperazine is not only superior as a solvent of uric acid and urates to all previous remedies, but also is free from their disadvantages.

5. Piperazine does not render the urine alkaline and so favor the deposition of phosphates.

6. Being free from caustic or irritant action, piperazine has been used successfully and without any ill effects for the irrigation of the bladder in the treatment of vesical stone.

***

SIMPLE CURE FOR HICCOUGH.—So many accounts of death from hiccoughs have appeared and so numerous have been the remedies suggested that it seems almost futile to add another, but this account by a writer in the *Medical and Surgical Reporter* is worth trying for its simplicity. He says :

"I was just about to send a cure for hiccoughs to the New York man whose case had been puzzling the doctors, when I read that he had been cured by laughing heartily at a colored man's description of what seemed to the patient a most ridiculous cure," said a Pittsburg physician. "You hear of numerous cures for hiccoughs, such as holding your fingers in your ears and having someone give you a drink of water, holding one's breath for a period, etc., but I doubt if any will stand the test as well as a practical cure, which for twenty years has never failed me once in all the hundreds of cases I have tried it. It may seem just as ridiculous as the cure proposed by the colored man in New York—so ridiculous that many will not think it worth while to try; it may be, nevertheless, a sure cure."

"All you have to do is to lie down; stretch your head back as far as possible; open your mouth widely; then hold two fingers above the head, well back, so that you have to strain the eyes to see them; gaze intently upon them and take long, full breaths. In a short time you will be relieved of that troublesome hiccough."

"Now I have tried that cure on all sorts of cases, from the simple form to the chronic, and it works well with all. I remember it was given to a man on the way to New York to consult a specialist on his case—one of six month's standing—and it cured him in a few minutes. He turned around and said: "What do you charge for that?' 'Nothing,' was the reply, 'except that you publish it to sufferers.' "

***

THE MENOPAUSE.—The menopause, or "change of life," is a matter of great importance in the minds of the laity and unfortunately too little considered by the profession. Dr. Byron Robinson, in an article on the subject in the *Journal of the American Medical Association*, draws the following conclusions:

1. The average menopause lasts two and one half years.

2. It comes on slowly as puberty does.

3. A stormy puberty means a stormy menopause generally.

4. The general rule is that an early puberty means a late menopause. In

my opinion it simply means that early puberty and late menopause rest on a largely developed abdominal brain and hypogastric plexus. A vast nerve supply means also a large blood supply. Precocious puberty means well developed genitals and ganglionic nerves.

5. The disturbance at the beginning of puberty is profound, but since it is an active (depletive) physiological process it quickly fits the growing and adaptive nervous system. But the menopause is a destructive process. It breaks up the harmony of the previous processes and unbalances the even distribution of nervous energy and circulation.

6. It is probable that every viscus receives an equal or greater shock at menopause than at puberty.

7. The changes at menopause consist in menstrual cessation, atrophy of the genitals and the hypogastric plexus.

8. Women do not suffer at the menopause so much from malignant diseases as they do from nervous troubles, neuralgias, mental deviations, disturbed visceral rhythm, disordered circulation, indigestion and above all neurosis.

9. The heat center (flashes), the vasomotor center (flushes) and the sweat center (perspiration) are the especial centers disturbed. Excessive, deficient or disproportionate blood supply characterizes the disturbed phenomena of these centers.

10. The etiology and pathology of the menopause lies in the sympathetic or ganglionic nervous system.

11. The systematic pathological stages in menopause are: *a*, a focus of disease, or irritation (the genitals); *b*, indigestion; *c*, malnutrition; *d*, anemia; *e*, neurosis. It is a slow progressive process.

12. Atrophy is a disease just as much as hypertrophy or inflammation.

13. Chief among the actual diseases in the menopause is endometritis. The peculiar floodings doubtless depend on this inflammation.

14. The menopause is characterized by various discharges (mucous membrane), leucorrhea, bronchitis, hemorrhages from the bowels, epistaxis (skin) perspiration.

15. Circulatory, perspiratory and caloric changes are the common heritages of the menopause.

16. A characteristic phenomenon of the menopause is an unbalanced, unstable nervous system, cerebro-spinal (irritable); sympathetic (debility).

17. Debility characterizes the trouble in the ganglionic system, while irritability characterizes the cerebro-spinal axis.

18. The explanation of the various phenomena is only possible through the nervous and circulatory systems.

19. Excessive sexual desire at the menopause is indicative of disease.

20. In the menopause the nutrition is impaired, as is shown by the occurrence of malignant disease in the sexual organs which are in a state of retrogression.

21. A chief feature characteristic of uterine disease is malnutrition from atrophy, curtailing blood supply suddenly, from the sudden degeneration of the genital nerve apparatus and consequent impaired control of tissue by a defective nourishment. Ulcerative surfaces, local death and purulent secretions arise from low granular cell formations.

22. In the menopause a disturbed point has arisen in the harmony of visceral rhythm. This pathologic focus must be looked on as the cause of the innumerable reflex neuroses at this time of life.

23. A reflex neurosis is a disturbance in distant organs caused by the irritation of a peripheral sensory or motor area.

* * *

Fracture of the Ankle-Joint.—Conservatism in surgery is always appreciated, particularly by the patient. Dr. Franklin G. Balch relates in the *Boston Medical and Surgical Journal* five cases of compound fracture of the ankle-joint, in which good results were obtained by conservatism, when there seemed to be very little hope of saving the member. His conclusions are:

1. That, at any rate in the case of poor patients, it is worth while to try to save the leg, even when the ankle is so severely injured that the chances of a

movable joint appear very small. To a poor man the appearance of the ankle, and the slight lameness caused by some loss of motion in the joint, are of little importance in comparison with the expense and trouble of an artificial leg.

2. That a very good way of treating these fractures is on a posterior wire-splint. This splint allows us to easily adjust the fragments from time to time, as the swelling goes down, while the foot is held firmly in the right position.

3. That the best dressing is the dry dressing of sterilized gauze, with iodoform gauze for drainage, when necessary. In certain cases a wet antiseptic dressing will hasten the separation of sloughs; but, as a rule, the dry dressing is to be preferred.

* * *

DIABETES.—Unschuld (*British Medical Journal*) draws attention to some of the less noticed symptoms in early diabetes, masked by the presence of dyspeptic symptoms, nervous symptoms classed as neurasthenia, etc. Sometimes diabetes may quite accidentally be discovered. Here marked thirst and abundant urine were mostly absent. Frequently cramp in the calves is complained of, a symptom at present but little recognized. During the past eight years the author has found it in as many as 26 per cent. of his cases. In 1891 he found it 33 times among 109 cases. It most often occurs in the morning, but sometimes at night. If such cramps occur and the patient complains of weariness and weakness, the urine should be at once examined for sugar. These cramps may be present in all forms of diabetes, except in the acute disease occurring in young subjects. Massage and attempts at walking generally relieve the cramp. The cause is obscure; perhaps it is due to the diabetic toxins. The recognition of these cramps may lead to the early diagnosis of diabetes.

* * *

WHAT WE MAY SEE IN THE SPUTUM.—The *Medical and Surgical Reporter* says that microscopical examinations have so far superseded the older methods that we frequently overlook many valuable points of diagnosis that might be observed with the unaided eye. We may first observe the quantity, reaction and consistence.

Patients with bronchitis or cavities, and especially cases of bronchiectasis, have the largest quantity.

Unless contaminated with vomited matter, sputum is always alkaline.

Mucus sputum usually occurs early in acute bronchitis.

Muco-purulent sputum in chronic bronchitis and in phthisis, or in later stages of acute bronchitis and pneumonia.

Purulent sputum (nearly pure pus) indicates a cavity or an empyema.

Serous sputum is fluid, and contains albumen, and is frothy. Characteristic of edema of lungs.

Blood expectorated from the lungs is usually bright red, frothy and alkaline. From the stomach it is dark, nearly brown, and acid in reaction.

Coal soot makes a black or gray sputum.

Fibers and pieces of lung tissue indicate a cavity.

Fibrinous casts indicate fibrinous inflammations. These are frequently found in croupous bronchitis.

* * *

ANEMIA WITH CORD CHANGES.—In the last number of *Brain* appears a paper summarized in the London *Lancet*, of more than usual importance, by Dr. H. M. Bowman, in which, in addition to an interesting record of a case of this nature, there is also given a short account of the several more or less interesting papers which have described this condition and recorded cases in which it occurred. The patient was a woman aged fifty-three, who was first admitted to hospital on account of great anemia, weakness, and headache. Examination of the blood revealed an excessive poverty both in cells and hemoglobin. Under treatment with arsenic the patient made a rapid recovery, and although still pale and somewhat feeble when she left the hospital to go to a convalescent home she was in a condition which might be described as one of fair health. A few

months later, however, she relapsed, and when again admitted she had already been unable to walk for a month. She was found to have some feebleness of the upper limbs and considerable weakness of the lower, so that there was just ability to raise the heel from the bed. The legs were subject to severe and sudden involuntary spasms. There was slight ataxy but no tremor, and there was impaired sensibility in the lower limbs. The knee-jerks were very active, but no ankle-clonus was found. The sphincters were unaffected. Her condition became gradually worse, the anemia increased rapidly, sensibility became more affected, the legs became rigid and motionless, and ankle-clonus was present. The arms also became much weaker, so that the patient could scarcely move them; troublesome vomiting was occasionally present, and towards the end numerous retinal hemorrhages were visible. There was incontinence both of urine and feces, and the patient died six months after her second admission and fourteen months after her first. At the necropsy, besides the anemic state of the various organs, the only abnormality visible was a cyst, apparently of inflammatory origin, situated in the head of the pancreas and communicating with the duodenum. The spinal cord, after hardening and staining, was found to have extensive areas of sclerosis, most marked in the posterior columns, but present also in the lateral and in the anterior. The walls of the arteries were greatly thickened in the most advanced areas of degeneration, and slighter changes were present in the areas in which the sclerosis was not so intense. Dr. Bowman, in concluding his paper, considers the question of the relation of these changes to the anemia, and after discussing the various points which such a consideration raises he throws out the suggestion that the cases of which his patient formed an example, in which spinal symptoms of a somewhat anomalous type are associated with grave and progressive anemia, are to be regarded as belonging clinically and pathologically to the group of postero-lateral sclerosis, or ataxic paraplegia, and that it would be unwise, until further light is thrown on the subject, to be too positive as to the relation of the nervous symptoms to the altered blood state. He himself, however, is inclined to regard the anemia as primary, and probably the cause of the changes in the cord.

* *
*

Puerperal Fever and Influenza.—Lefour (*British Medical Journal*) discussed the question of diagnosis before a meeting of the Obstetrical Society of Bordeaux. He believed in Labadie-Lagrave's principle of examining the blood. If streptococci were detected septicemia existed, whilst if severe fever set in during childbed when no streptococci could be found, the rise of temperature was due to influenza. Oui objected that septicemia was not always due to the streptococcus; the bacterium coli might play a great part in infection. Rivière stated that he had made researches in the bacteriological laboratory. The results had been most irregular. No micro-organism was found in the blood of a woman who was clearly suffering from puerperal fever, and not from influenza. In other cases he found the streptococcus; in others, again, the staphylococcus. André Moussous noted that in influenza secondary infection was very frequent, especially in childbed. Hence Labadie-Lagrave's rule was hardly to be trusted. Coyne was of the same opinion. He quoted the authority of Bouchard, who found all kinds of micro-organisms in pure influenza.

* *
*

Myoma and Vaginal Hysterectomy.—Ruge (*British Medical Journal*) exhibited, in May, at a meeting of the Berlin Obstetrical Society, a uterus which he had removed through the vagina. It was regularly distended by a submucous myoma, and measured over eleven inches in circumference. He noted that, by aid of *morcellement*, a uterus much larger than the present specimen could be removed through the vagina, and that this operation was the best of all the more serious and radical procedures undertaken for fibroid disease of the uterus.

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See Publishers' Department, Page 416.

BALTIMORE, SEPTEMBER 8, 1894.

When May Syphilitics Marry?

Some time ago Dr. W. G. Porter of New York wrote an article on the marriage of syphilitics, asking if they should marry. More recently Dr. William S. Gottheil, recognizing that a man, in love or not, will do as he pleases, and without attempting to restrict the marriage of syphilitics, very practically asks when may they marry, for marry many of them will, with or without permission. He says that a man who has had syphilis is damaged for life; his tissues are more vulnerable and less resistant.

We may give our advice or even our orders to a syphilitic not to marry, but we must remember that the sentimental, esthetic and social considerations have so preponderating a value that the medical and hygienic factor is almost neglected. Most syphilitics, if they feel well, and many if they wish, marry without our permission; still of these who would not heed our advice not to marry at all, some would be governed by our counsel as to when they could safely marry, and Dr. Gottheil has formulated the following scheme which, of course, will not be agreed to by all, as such a variety of opinions hold on this subject:

1. Syphilitics may not marry:

(*a*) During the entire primary stage, from first appearance of the chancre to the entire disappearance of the induration and the inguinal adenopathy. This stage will last at least six months. Secondary symptoms will almost always appear during its continuance, and it will run into the next one. If they do not, a further delay of twelve months is necessary, to await them.

(*b*) During the entire secondary stage, the period of the general eruptions, multiple mucous patches, adenopathies, alopecias, etc. This stage lasts at least twelve months, and is rarely prolonged over two years. But it is not the time so much as the generalized character of the disease manifestations, showing persistent infection and prolonged contagiousness, that marks its limits.

2. Syphilitics may marry:

(*a*) When the disease is in its tertiary stage. This stage lasts from the disappearance of the general symptoms to the end of the patient's life. He may or may not have symptoms of the disease or its sequelæ, but it is no longer contagious, and he cannot communicate it to his partner.

(*b*) When a period of one year has elapsed since the appearance of the last symptom of the disease.

* * *

Abuse of Arsenic in Skin Diseases.

The fact that arsenic has been of great service in some forms of skin disease is so well known that even the public has a hazy idea that this drug will remove all skin defects and give a perfect complexion. That arsenic is used too often and with too little knowledge of its general effects is a fact that is beginning to be appreciated.

Dr. Isadore Dyer, in writing on the use and abuse of arsenic in the treatment of skin diseases in the *Medical News*, says it is hardly to be wondered at that the general practitioner should welcome a remedy which had been so widely praised by skin specialists. It is used in a routine manner by general practitioners who have no idea of its action and are ignorant of the fact that it not only does

not help in some troubles but actually does harm and makes the case worse. Used locally, arsenic is a stimulant and irritant and later a caustic. Internally it is a nerve-tonic, a direct stimulant to nutrition and an alterative. It acts on the epithelium of the skin ; it is especially serviceable in chronic eczema, lichen and hydroa and some find it very efficacious in psoriasis.

Persons who use arsenic without medical advice and often even those who do, are surprised at the effects on the skin, and whether it is due to its cumulative action or to some idiosyncrasy at the time, the skin becomes violently inflamed and breaks out after several days' ingestion of the drug.

As so many accidents occur in the course of the administration of this drug, it is well to call a halt and not use it indiscriminately. The conclusion of this matter seems to be that arsenic should be one of the last remedies used in the treatment of skin diseases and when prescribed it should only be selected in chronic cases with a general distribution and in diseases associated with a neurotic element.

* * *

Reports of Society Proceedings.

THE time is rapidly approaching when the various medical societies in the cities will begin their winter work and the respective reporting secretaries will have the arduous tasks of noting discussions and remarks and making them known by some medium to the medical public. A contemporary has pointed out the difficulties of this work and how little its importance is appreciated. Is it better to have a stenographer to take verbatim reports of each and every word uttered, or cannot an intelligent young physician jot down sufficient notes in long hand to make up a readable report ?

There are in every city a few reliable medical stenographers and to secure their work is not easy, for they command prices beyond the limit of many societies. An ordinary stenographer may report like a phonograph, but he is very likely to misspell and make nonsense because of his unfamiliarity with medicine. As a rule, long discussions are not read with pleasure unless the subject is of exceptional interest. In some societies the speakers are trained to reduce their remarks to writing as soon as they have finished speaking, but this is such a task that some willingly forego the pleasure it gives them and others of speaking rather than perform this unwelcome task. In other societies the secretary takes notes as best he can and then sends each speaker his remarks for correction. As a rule the speaker rewrites what the secretary has with great pains put down and while the latter has faithfully recorded what was said at the meeting, the speaker, being in a cooler frame of mind and having text-books at hand, proceeds to write down a long harangue, not only what he did say but what he ought to have said, but forgot or never knew before until he consulted his books. The result is a long report, each speaker reading his own remarks with great pleasure to himself.

The great fault of medical societies is that too long a time lapses after the meeting and the publication of reports. If members will not write out their remarks at the time immediately after sitting down, then the secretary should take his own notes and finish the report and get it before the public as soon as possible. Where the services of an intelligent medical stenographer cannot be secured, a quick and careful man who uses long hand with tolerable rapidity may be engaged and he can paraphrase the remarks as they are uttered and so present them that the vain repetitions and padding are omitted, and the facts are thus brought out the more prominently.

The best work in a society is done in the discussions and if these are not recorded and that promptly, the most attractive part of the proceedings is left out and the able men who write little and observe much are not brought forward in their proper place. If medical societies continue to increase in number as specialties increase and if the discussions grow longer and longer, the matter will remain unread and much better material will be crowded out to make room for this padding.

* * *

THE antitoxin treatment of diphtheria bids fair to outrival the tuberculin treatment of tuberculosis. Dr. Herman M. Biggs has studied the methods abroad and gives very favorable reports, and the endeavor will be to get a large appropriation from the Health Board of New York to try this cure there. Philadelphia will also follow this example. Meanwhile the more conservative cities can afford to wait until experience and time show just what this new method of treatment is worth.

MEDICAL ITEMS.

The increase in the consumption of tea last year was 6,000,000 pounds.

A statue to Claude Bernard will be unveiled at Lyons, on October 26.

Dr. Charles P. Noble of Philadelphia has removed to 1637 N. Broad Street.

The death is announced of Professor Rollet of Lyons, the well-known syphilographer.

The regular monthly meeting of the York County (Pa.) Medical Society was held August 2.

Dr. James C. Welling, President of the Columbian University at Washington, D. C., died last Tuesday.

Dr. Danielssen, the well-known authority on leprosy, died recently at his home in Norway at the age of seventy-nine years.

Dr. James F. McShane will attend the meeting of the American Public Health Association at Montreal this month.

The only medical school in this country that requires a liberal degree for admission is the Johns Hopkins Medical School.

Dr. John S. Billings made an address on diphtheria at the International Congress of Hygiene and Demography at Buda-Pesth.

A Nebraska court has decided that under the medical law of that State a "Christian Scientist" is debarred from practicing medicine.

The daily papers report a case of sporadic cholera at Cumberland, Maryland. It was traced to a German steamer arriving in New York.

The Washington authorities dumped their garbage on the Virginia shore of the Potomac until that State objected, and now the Maryland side receives the dirt.

The *West Virginia Journal of Medicine and Surgery* is a very large name for a very small monthly at two dollars a year. The editors deserve credit for their pluck.

The *Texas Medical Journal* says it begins to look as if the National Association of Railway Surgeons is to be a kind of kindergarten for the education of witnesses for the future.

The *Richmond Journal of Practice* has a very readable department headed "Original Interviews," in which views as obtained by a personal interview of a representative of the journal are recorded.

Dr. George M. Phillips of Maysville, Kentucky, a graduate of the College of Physicians and Surgeons of Baltimore, has been elected Professor of Genito-Urinary Surgery in Barnes Medical College, St. Louis.

Dr. Landon B. Edwards, editor of the *Virginia Medical Monthly*, was elected president of the Medical Publisher's Association which met at Hot Springs, Virginia, last month. The next meeting will be held in Baltimore next May.

The University of Pennsylvania is about to erect three new buildings, all connected with the medical department. These are the Agnew Memorial Wing to the Hospital; the William Pepper Clinical Laboratory; and a main ward to the Maternity Hospital.

Dr. Charles J. Osmun, for years chief Sanitary Inspector for the District of Columbia for infectious diseases, died in Washington recently from malignant diphtheria contracted during the discharge of his duty. His successor in office is Dr. Austin O'Malley.

Dr. Henry W. Webster of Baltimore died on August 29, of Bright's disease. Dr. Webster was born in 1830 and was graduated at the University of Maryland in 1850. He was the only one of seven physicians to survive the yellow fever epidemic at Norfolk, Virginia, in 1856. Dr. Webster leaves a son, Dr. Henry W. Webster, Jr.

At the International Congress of Hygiene and Demography, to be held at Buda-Pesth this month, Dr. Ayres, the principal medical officer to the Chinese Government, will send a full report of the bubonic plague, and Dr. Simpson of Calcutta, in conjunction with M. Haffkine, will present an important paper on the comma bacillus.

The remarks of Dr. Osler at the recent dinner of the Harvard Medical Alumni Association that 33.3 per cent. of the women medical students at the Johns Hopkins Medical School has been married at the end of the first session, has been gravely quoted by the medical press as a failure in co-education. Dr. Osler very properly asks what will happen at the end of the fourth year? The remaining two women in the class stand a poor show of graduating.

BOOK REVIEWS.

MACROBIOTIC; OR, OUR DISEASES AND OUR REMEDIES. For Practical Physicians and People of Culture. By Julius Hensel, Physiological Chemist. Translated by Professor Louis H. Tafel, of Urbana University, Ohio. From the Second Revised German Edition. Philadelphia: Boericke & Tafel, 1894. Pp. 6–7 to 201. Price $1.50.

This is either a very advanced book or the product of a diseased brain. It sets forth strange theories and puts down remarkable methods of treatment. All disease is supposed to be due to diminished electric force, the cause of which is insufficient oxygen. The whole theory of the therapeutics suggested is on a chemical basis. That the book has gone through two editions is beyond all comprehension. When writers get too far ahead of the times, they are not understood and are set down on as cranks. The remedies are hardly such as will be used by the general profession. From the publishers' imprint there must be homeopathic principles lurking about it somewhere.

REPRINTS, ETC., RECEIVED.

Practical Application of the Principles of Sterilization. By Hunter Robb, M. D. Reprint from *The American Journal of Obstetrics.*

The Operation of Vaginal Hysterectomy by Enucleation due to Langenbeck. By Robert Reyburn, M. D. Reprint from *The Medical News.*

Vaginal Hysterectomy for Carcinoma of the Uterus Performed by Enucleation without Hemorrhage. By Robert Reyburn, M. D. Reprint from *The Medical News.*

Treatment of Inoperable Malignant Tumors with the Toxines of Erysipelas and the Bacillus Prodigiosus. By William B. Coley, M. D. Reprint from *The American Journal of the Medical Sciences.*

The Comparative Rarity of Pulmonary Tuberculosis in the Highlands of Pennsylvania and the Adjacent Counties of New York. By Guy Hinsdale, A. M., M. D. Reprint from *The Medical News.*

A Hogemeyer of Berlin announces the appearance of a description of the new hospital of the city of Berlin "am Urban," together with a report on its internal arrangement and its administration. The price is $1.50.

CURRENT EDITORIAL COMMENT.

EYE-STRAIN.

Therapeutic Gazette.

THE vast majority of careful ophthalmic surgeons are not disposed to reject drugs which experience has proved as the most necessary articles in their armamentarium, in spite of the contemptuous references to the "old-fashioned" practice of dilating the pupils before selecting suitable glasses for the patient, which are occasionally heard.

MONUMENTS.

Medical World.

THE true monument is not a useless, expensive shaft or pile of masonry, but the foundation of a school of learning, a library or other public institution for the advancement of science, the uplifting of the race or the amelioration of suffering, or the endowment of a department, chair of research in certain branches, a scholarship, ward or bed in some already existing institution. This kind of a monument is constantly alive, warm and reproductive.

PROGRESS IN MEDICINE.

Southern California Practitioner.

IN medicine as elsewhere, there are two schools of thought, the optimist and pessimist, and to which group the individual physician may belong depends partly on his natural mental bias. The many new therapeutic measures which are continually brought to our notice are so confusing and the reports as to their merits so conflicting that very many are apt to cry the olden times were better, and to think after all the boasted advance in medicine is but idle whistling to keep our courage up. Others hail with loud acclaim every new drug or theory only to cry "the king is dead, long live the king," when yet another remedy is announced. But there is here as in all other arts a golden mean. Not all promises are fulfilled, still a steady advance can be noted. Vaccination and anesthesia are the products of modern medicine. Electrical cataphoresis enables precise doses of almost any drug to be applied to any disordered region. Modern asepsis has rendered possible bold and skillful surgery. Prophylaxis is the result of recent investigations. During the past year the employment of the thyroid gland in myxedema has been a pronounced success, and was due also to rational deductions from careful experimental researches.

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TO PRACTITIONERS OF MEDICINE.

The Medical Law as repealed and re-enacted, with additions and amendments, by the Maryland State Legislature, has been printed at this office in neat and convenient form for physicians. Copies may be obtained at the Journal Office or will be forwarded by mail on receipt of 15 cts. in stamps or coin.

NOTES.

ALUMNOL, as reported by Cantrell, is very efficacious in a variety of skin affections.

*

TUSSOL, a combination of amygdalic acid and antipyrin, is used in whooping cough.

*

NOTHING is better in cystitis than irrigation with weak solutions of corrosive sublimate.

*

STRONTIUM lactate is a very powerful diuretic and especially useful in Bright's disease.

*

THIAFORM is an odorless, non-toxic drug much used in the treatment of burns and ulcers.

*

WOOL-OLA, a new preparation made in this country, is said to be as good as lanoline and much cheaper.

*

DJAMBOE is employed by the Javanese as an astringent and stomachic and is especially useful in diarrhea.

*

LANOLINE and ichthyol rubbed into the affected parts will rapidly cure lumbago and rheumatic pains.

*

ATROPINE in doses gradually increased to full limit of tolerance will rarely fail to cure cases of nocturnal enuresis.

*

HOT bichloride poultices are recommended in nervous septic conditions, after incision and for drainage.

READING NOTICES.

Hæmoferrum.—A case of gleet of long standing was successfully treated with Hæmoferrum (Stearns') by Dr. Normandis, New Bedford, Mass.

*

For Dyspepsia.—

℞.—Tinct. Colombæ . 2 oz.
Celerina [Rio] . . 6 oz.
M. Sig. Teaspoonful thrice daily.

*

Listol.—Listol, though a comparatively new drug, is rapidly gaining the endorsement of the physicians who have taken the trouble to give it a trial, and it is already replacing iodoform in the many conditions in which the latter drug has been employed. Listol, when applied in dry powder to a wound, forms a coating and protects the injured surface from atmospheric poison, and prevents suppuration.

*

Pinus Canadensis.—R. W. St. Clair, M. D., Brooklyn, N. Y., says: I have used S. H. Kennedy's Extract of Pinus Canadensis for two years, in a large practice, and so far have never failed in reaching the most happy results. One case of nasal catarrh, that resisted the best treatment of some of our best practitioners, came to me. I began with Pinus Canadensis, and am pleased to say that the cure is absolute.

*

Sulfonal.—Sulfonal does not weaken the heart action, and hence it forms an excellent hypnotic in acute debilitating diseases attended with insomnia. In discussing the present treatment of pneumonia, Dr. Peabody (*Medical Record*, December 16, 1893), expresses his preference for Sulfonal over opium and chloral, and these views are shared by a large number of the profession.

*

Trional.—The requisites of a satisfactory hypnotic for general use in medical practice are reliability and promptness of action, ease of administration, freedom from toxic or unpleasant effects, and from the risk of a habit. Trional is a hypnotic of exceptional value. In an interesting article in the *New York Medicin. Monatsschrift*, December, 1893, Dr. L. Stieglitz reports his experience with this remedy in 58 cases of insomnia occurring chiefly in neurasthenic and hysterical patients and expresses the opinion that Trional best meets the demands of the practitioner for a prompt, safe and effective sleep-producer.

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ORIGINAL ARTICLES.

DILATATION OF THE STOMACH, WITH REPORT OF TWO CASES.

Read Before the Baltimore Medical Association, February 26, 1894.

By J. T. King, M. D.,

Baltimore.

There is no absolute standard of size for the normal stomach any more than for the normal head. We may find a very large head on a very small man, or *vice versa;* the same may be said of the stomach. But when the capacity of the latter exceeds sixty fluid ounces we raise no question of abnormal dilatation, yet the organ may hold less and be relatively dilated for the subject; when, therefore, I use the term dilatation of the stomach I mean that condition of an enlarged viscus which presents clinical features of diseased action. The two cases to which I invite your attention are interesting as having distinct and dissimilar causes for their origin, and in their history consequent individuality, if we may so express it.

The first case I believe was functional in its origin. My second cancerous. It is so important that we differentiate early between functional and organic dilatations, for if we permit the causative conditions of the first to continue unchecked they will almost certainly be transferred into the second.

My first case was a lady of 65 years who had been ill for about ten years and "had suffered many things of many physicians, and grew not better, but rather worse." I should like to state just here that we as physicians are apt to seek for cases of dilatation only among those advanced in life, and forget that while experience teaches us that the vast majority may be found past middle life; it is no uncommon thing to find children with this affection. This case presented all the symptoms of exaggerated dyspepsia. Marked emaciation, discomfort after eating, with abdominal distention, foul breath, coated tongue, constipation of the bowels, tenderness over the epigastrium—but the most prominent feature was vomiting. In the early history of her case, she informed me, the vomiting occurred almost immediately after eating, but when I first saw the case several days would elapse between the periods of vomiting, though when emesis did occur the amount of ingesta was at times enormous, even more at times than had been taken, for the remnants of former meals which accumulated in the stomach were added. I took no hope from the knowledge that the vomiting occurred less frequently, for aside from the fact already stated that the amount lost each time was very large, I felt certain that the quiet was produced by increasing relaxation of the muscular walls of the stomach, and that finally

paralysis of that organ would ensue. Before vomiting, after the accumulation of food for days, sometimes a week, the curvature of the stomach could be distinctly seen an inch or two below the umbilicus, while after vomiting the organ would disappear from view. By placing the hands flat upon the abdominal walls over the region of the stomach, and with the fingers giving rapid and successive taps, or by shaking the entire body succussion or splashing sounds were distinctly heard. No tumor of any kind could be found either in the stomach or other abdominal organ. Diagnosis: Dilatation of the stomach from weakness of the gastric muscle.

Doubtless a combination of causes led to this weakening of muscular tone. Probably over-eating, and consequent slow digestion, with abnormal formation of gases and closure of the orifices. For I was informed that my patient had most of her life been a hearty eater. Later, owing partly to mechanical distention, partly to venous congestion connected therewith, structural changes were produced both in mucous lining and muscular walls, with degeneration and finally muscular insufficiency of the organ. This patient passed from my care by her removal to another city, not "a better." I was not surprised, however, to learn a few months later of her death by marasmus, and was interested to ascertain that the post-mortem did not reveal any malignant change, or constricting cicatrix of the pylorus. The stomach was immensely dilated, and had pushed aside all the abdominal viscera, pressing upward the diaphragm, and thus impairing to a degree the action of the thoracic organs.

I know that some authorities state that functional dilatation is never fatal, but one fact is worth more than a thousand theories unestablished.

My second case, the specimen of which will be presented to you by Dr. Chambers, was a gentleman of 54 years, a bank officer. This man had seldom sought medical aid, and was absent from his bank scarcely a day in the year. I was first invited to prescribe for him for diarrhea about a year prior to his death, complicated with ordinary symptoms of dyspepsia. It was about five months later that I could palpate a small tumor in the right hypochondrium, just below but distinct from the liver. He began at the same time to develop the peculiar and characteristic cancerous cachexia. No vomiting. Indeed, vomiting in this entire case was conspicuous by its absence. The diarrhea soon gave place to obstinate constipation. Pains in the epigastrium increased. The stomach filled with its contents would project like an immense encysted dropsy, pressing aside the neighboring organs, especially the lungs, heart, liver and intestines, and causing disturbance of their functions. Though there was no exaltation of temperature, as shown by the thermometer, except when near the termination of the case, and that hectic thirst was insatiable, the skin dry and scaly. This condition was caused by the non-absoption of water, for the fact is established that while the stagnation of the stomach contents exerts no appreciable influence upon the secretions of the mucous membrane as long as the secreting elements remain intact, it disturbs absorption very seriously. Pains in the extremities were more or less pronounced, due doubtless to the same lack of supply as in cholera.

Another thing Dr. Chambers will tell you about is the examination for free hydrochloric acid. It is now generally accepted that where the stomach is seriously invaded by cancer the secretion of free hydrochloric acid ceases, and this fact will often serve us in reaching a proper diagnosis; but given a localized cancer, with the mucous membrane intact, hydrochloric acid may be found within a short time of death.

Dropsy of the lower extremities appeared with great distention of the stomach, and disappeared with the emptying of the organ by percolation. An interesting feature of this case was the waves that could be distinctly recognized through the attenuated abdominal walls, passing through the stomach from right to left and from above downward. As the case advanced these

waves grew less and less. These peristaltic motions served to show the enlarged boundaries of the stomach.

Had I the time I would enter freely into the question of differential diagnosis, but I have already exceeded the bounds of my paper; so I will but mention the conditions for which we may mistake this disease: Impacted feces in the transverse colon or jejunum, distention of the colon, encysted dropsy, cysts of the ovaries, kidneys or spleen, gastric ulcer, or even hysteria in old women when accompanied by repeated vomiting.

In addition to the means of diagnosis already suggested there are others to which I would refer.

We may determine frequently the dilatation of the stomach by introducing a sound or stomach tube, and palpating the point through the abdominal walls. This mode may be misleading in a case where the stomach is vertical. Or we may inflate the stomach with air or gas, or fill it with water, and carefully mark the outline.

Again, to determine the atony of the stomach which invariably accompanies dilatation, we have the test meal and salol methods. For a test meal we might give a few ounces of soup with cold meat and a slice of bread. In ordinarily fair digestion the stomach should be empty in six or seven hours. If we find after that time has elapsed by lavage the remnants of food it shows the want of propulsive power.

Again, we administer fifteen grains of salol, which should appear by absorption from a healthy stomach in the urine in one hour as salicyluric acid; so by repeating the test each subsequent hour we may determine the period of delay. I will close this paper with a few words as to treatment. I believe the opinion is generally accepted that where once dilatation is begun in the stomach, as in the heart, we have no means of absolute cure. But we may do much to prolong life and make our patients comfortable, particularly in cases of functional muscular atony, by regulating the quantity as well as the quality of food and also the hours of feeding. We should administer, as I did in these cases, food in small quantities, if necessary predigested, milk, peptones, meat extracts and the like. Where vomiting is obstinate, or where absorption from the stomach is *nil*, we must feed per rectum. Lavage in many cases, non-malignant, is a most valuable agent.

Hydrochloric acid, salicylate of bismuth, strychnine or nux vomica, faradization, gentle massage, may all be used in appropriate conditions. Last of all, surgery has been invoked to help us in these desperate cases. The late Professor Billroth operated successfully in the resection of the stomach for dilatation. If it has been done in this country I have failed to see mention of it. The question of auto-infection would naturally arise in the consideration of this subject. Is it possible where food is so long retarded and where fermentation occurs with decomposition for poisonous elements to be generated and absorbed into the system? The weight of authority appears to be in favor of this opinion.

NOTE.—Autopsy by Dr. J. W. Chambers. Cadaver greatly emaciated. Stomach so dilated as to crowd aside all the abdominal organs, the most dependent portion, or lumen curvature, being in juxtaposition with the bladder. Dissection revealed stenosis of the pylorus from carcinoma.

SPONTANEOUS CURE OF DETACHMENT OF THE RETINA.—Armaignac (*British Medical Journal*) relates a case in which a child had been struck in the left eye by a wooden arrow. There was a wound of the cornea through which some vitreous was protruding; the pupil was dilated and fixed; the lens was displaced slightly downwards, and the vitreous contained blood. A fortnight after the vitreous was clear, but there was an extensive detachment of the retina to the nasal side. Pilocarpin was ordered to be dropped into the eye. Six weeks later, however, the retina had become attached again; the pupil remained dilated and inactive and a complete examination revealed no trace of the previous detachment except a mass of pigment. The vision had become almost normal again.

CHRISTIAN SCIENCE AND ITS RELATION TO THE MEDICAL PROFESSION.

Read before the Medical Society of the State of Pennsylvania.

By Hildegarde H. Longsdorf, A. M., M. D.,
Carlisle, Pa.

In appearing before you on this occasion I feel it due myself, as well as this learned assembly, to offer a partial explanation of my purpose in so doing. For otherwise it would certainly savor on my part of the arrogance of conceit, or an unwarrantable assumption of privilege, to attempt to address on a medical subject such an august company of veterans and superiors in an art where at most I can only be a tyro.

The papers read here are presupposed to come from those whose skill and knowledge have brought honor and repute to their names and value to their slightest utterence on such topics as habitually arise on occasions like this. Far be it from me to invade such a field, only to illustrate by my temerity the time-worm maxim that "fools rush in where angels fear to tread."

But while the primary object of our meeting is mutual discussion of the more immediately important medical subjects, and instruction from those who are so well able to give it, there are also closely allied and leading up to these, many subjects in the line of suggestion and inquiry which may pardonably be taken by the less gifted.

The subject, therefore, which I shall briefly consider here is one of these, not a purely medical subject from this standpoint, but rather one of those related subjects, which, though at first glance insignificant and even contemptible, yet from the proneness of the uninformed to exaggerate and mystify diseases and all remedial agencies—carry with them an overpowering influence, and, to the younger practitioner especially, are baffling and vexatious.

Such is Christian Science, probably the most pretentious and certainly the most successful of the out-growths of our modern high pressure civilization; which not content with its acknowledged empire over material nature, and subsidizing the results of scientific investigation, must needs enter the realm of psychological phenomena, and skilfully weaving therefrom a tissue of fact and fancy, spread it before the gaze of a too credulous public, call upon it to believe what it cannot explain, and revere what it cannot comprehend.

There have been many such mock systems in former, as in later years, most of them having for a basis the "divine art of healing," along with other pretentions to a spiritual or philosophical status, all wearing a more or less familiar guise to the reader of history. Christian Science, however, goes a step beyond any of its forerunners, is one shade finer, and more plausible in its theory, and more conspicuously successful than any similar intellectual epidemic the world has ever witnessed. It seems to unite and intensify into some semblance of symmetry; something of the Astrology and Prophetic Hallucination of the Ancients; something of the Religious Ecstacy and Mysticism of the Middle Ages; something of the progressive thought of the later school of the English scientists, and welding them together by the despotic power of that prescient imagination which, over-leaping the bounds of demonstrable truth, presents the result to the conservative thinker of to-day, as a reasonable doctrine, no less a universal panacea, for "all the ills that flesh is heir to." These fatuous misbeliefs are the intellectual scandal of our age, and while we must desire to apply some corrective influence, it becomes a puzzling question how to regard those who honestly believe in them and what should be the

attitude of the physician toward such as aspire, under its provisions, to the office of "healers."

In more accurately defining Christian Science, I would observe, that it must not be confounded with Hypnotism, Animal Magnetism, Faith or Mind Cure, Spiritualism, Clairvoyant or other trance, or the old-time powwowing processes which the practitioner in country districts still frequently encounters. All of these it somewhat resembles, having apparently some family features of all, yet differing in essential particulars. Christian Science pure and proper disclaims or ignores these agencies and claims a heaven-derived power of its own; and in this probably lies its greatest influence—for in all times a "divine right," stoutly asserted and skilfully maintained, has held its own against reason, logic and the evidence of the unprejudiced senses. There is no instinct so universal as that which responds to the intimations of the supernatural, and the most realistic among us must acknowledge this influence as a factor in certain diseases. We see it exemplified in the history of the earliest nations, and there we attribute it to ignorance, but the candid student must admit that the advanced intelligence of the later periods has changed the form, but not eradicated the inherent tendency.

To the primitive man death and disease appeared the immediate act of some invisible, but all-powerful being, who, from malice or rage or other human passion, dealt out dire punishment upon mortals. Hence his favor was sought and propitiatory rites and ceremonies were observed to avert disaster and suffering. But this is not to be wondered at. The ignorance of the ancients as to the true character and real origin of disease appropriately corresponded with their ignorance of the constancy of the phenomena of the external world. Subsequently, while the more cultivated and advanced nations were passing through the throes of a mighty religious revolution and the dismemberment of social structures was everywhere imminent, a further development of this natural attitude of man toward a Creator and the Universe took place, and a thousand abnormal manifestations of mind over matter were attested, until a mystical system, partly real and partly fanciful, was evolved. Under this system many delusions were experienced, by such as might be called honest believers, while jugglers and magicians in all fields, but especially so in those allied to the curing of disease, were rife.

Following the renaissance of art and literature, knowledge grew, and it may be that with a more general diffusion of the underlying principles of medical science, such as the uneducated mind can grasp, and a clearer apprehension of the import of recent discoveries in bacteriology and similar fields of investigation, the demonstrations which are now so constantly made to lead the masses back to the twilight ages, in this respect, will cease. But until this more general intelligence shall come to pass, we will doubtless continue to witness the phenomena of the blind gaining instant sight, the lame being made to walk, and the suppurating sore healed by a word; such alleged cures being regular occurrences in the vicinity of a properly qualified Christian Scientist. From these centers of abnormal experiences, ever widening influences diverge, and we shortly see vast numbers of enlightened and cultivated persons of both sexes and of every shade of religious belief accepting and propagating the ideas that form the basis of the popular manifestation.

Christian Science shrewdly appreciates the value of this prevailing tendency of human nature, and therefore, as its name imports, it is found to be a compound of *theology* and *the art of healing*—in these two sides expressing the strongest wants of mankind. Otherwise it calls itself the "Science of Health," and an elaborate treatise has been given to the public for the purpose of explaining its peculiar doctrines or principles, and setting forth the benefits which must accrue from its universal acceptance.

It was *discovered*, as its adherents put it, in the year 1866 by Rev. Mary Baker

G. Eddy, of Lynn, Mass. In giving an account of her discovery and preliminary experience, Mrs. Eddy says that she was impelled from childhood "to seek diligently after God as the one great ever present remedy for all human woe." She states that the physical side of this research was aided by hints from Homeopathy, to the conclusion that *mortal belief*, instead of the drug, governs the action of material medicine. She found in the remedies enumerated by Jahr that the pervading secret was that "the *less* material medicine we have the better the work is done," and she proceeds to prove that this is so by an illustration from this school of practice. "One drop of thirtieth attenuation of Natrum muriaticum in a tumblerful of water and one teaspoonful of water mixed with the faith of ages would cure patients not affected by a larger dose." The drug disappears in the higher attenuations of Homeopathy, and *matter* is thereby reduced to the proportion of mortal mind, but the curative principle remains and is found to be even *more* active.

She also relates her own experience, while in failing health, with a distinguished mesmerist. His method of treating her was by *manipulation* and water, and although she acknowledges that he had some advanced views along his own line of research, she pronounces "mind cure on a material basis" a kingdom divided against itself.

In a similar manner she argues against the efficacy of animal magnetism. It is interesting to note the elimination of her own peculiar idea from the prevailing influences of the times and her final success in reaching a standpoint *differing* from all her predecessors and thus gaining *originality* and *potency* for her cause. It must be confessed that there is something beautiful and attractive in the ideas thus expressed, and the most fastidious among us could take no exception (on the ground of ethical morality) to the tenor of her sentiments.

In her conclusions the odium of hypnotic experimentation is eschewed ; the ridicule attaching to clairvoyant and other mediumistic practices is avoided. She demonstrates, in fact, the spiritual attenuation of a noble idea, more subtle and dilute than any Homeopathy ever propounded; a metaphysical abstraction more elusive and beguiling than any hypothetical figment portrayed in the pages of German philosophies ; while there lingers about her doctrine a classic flavor not unworthy the noble parentage of Plato, who first taught the theory of Ideas or Essential Forms.

Each one of these was at once the prototype and the cause of a number of transitory existences in the sphere of the sensible. To these ideas, as to higher realities, phenomena were referred, and their explanation found in them by Platonism. Following along this line of suggestion, which every classic student has conned, we perceive that modern Christian Science is a restatement of an ancient principle, which has lived in and influenced metaphysical speculation in all ages.

It is, as we have seen, an old acquaintance with a new face, and its extraordinary progress has doubtless been due to the reactionary tendency of the times among a large class of orthodox people, from the scientific materialism, naturally growing out of the demonstrations going on here and abroad, as to the cause and prevention of disease.

Mrs. Eddy tabulates her theory on the understood dominance of supernatural *dread* or *fear* in most people, and at the same time skilfully evades direct issue with superstitious antagonisms, by calling *fear* another name for disease. She declares that "war is waged between the evidences of spirit and the evidences of the five physical senses." "Divine Science was against *sin*, *sickness* and *death*." And again, "All sensation is *mind* and mind is *God*," and further, "The notion of more than *one* mind is unsatisfying and unscientific." Her deduction, therefore, is that *mind* is synonymous with *Good* or *God* and per consequence at one *Life* or the principle of existence. All else is *material* and not to be considered.

Thus she directs the following formula. "Science saith, to all manner of disease, know that God is all-powerful and ever-present, and the sick are healed." Other

statements embodying this *science*, so-called, are made in the extraordinary book called "Science and Health," which is in a sense the Pharmacopeia of the new school, but it is on the basis of the foregoing that their practice is built up.

The patient is taught that sickness is a *belief*, a *latent fear* made manifest on the body in different forms of disease. "This *fear* is formed *unconsciously* in the silent thought, as when you waken from sleep and feel ill, experiencing the *effect* of a fear, whose existence you do not realize." But if you "fall asleep conscious of the Truth of Science, viz., that man's *harmony* is no more to no invaded than the rhythm of the Universe, you cannot awake in fear or suffering of any sort." Thus Christian Science aims at the highest medical ideal, the prevention, as well as the cure of disease. That *matter* cannot suffer was illustrated in a very simple manner by a very intelligent lady, a friend of mine, who while on a visit to the west, was lead to investigate, and finally become a convert to Christian Science. She said with much apparent conviction, "why if you would cut off your hand and throw it on the floor, it couldn't feel." "It is only your mind which is *spirit* that feels and *spirit* which is *God* cannot be diseased or suffer." So the whole belief in disease is *unreal*, a fantasy, the result of erroneous teaching, or latent fear, or sin.

This then, is the whole doctrine. Comprised in these somewhat enigmatical and contradictory statements, is the motive power of a system which has more strength than most of us would be willing to believe. If it were not for this fact, that it is rapidly spreading, gaining friends and influence among the most intelligent classes, we might well dismiss the subject with a smile ; as one more of the numerous phases in which the ever-restless mind, ever recurring to the unknown, ever tracing its circling course upon itself, seeking to find the cause from the phenomenon, has manifested itself.

But it has a vast and increasing power and not only among the uneducated. It has its representative literary journals, a system of propagating its tenets by pamphlets and tracts and books. It has an array of special agents or missionaries, a respectable showing of institutions or metaphysical colleges, extending over many of the different States, and a vast number of private establishments for the cure of every disease under the sun. Preaching and teaching come into the plan and to a thoughtful observer it seems as if the dark ages, when Demonology and Magic ruled the court, the camp and academic grove, were about to return.

The question arises how we are to regard it and how we are to be armed against its inroads. If mental force has a therapeutic value, if the mind can control not only the kingdom which of right belongs to it, but also the laws of matter and of physical sense. Then it seems as if our resources were inadequate and some form of definite action should be taken whereby we could cope successfully and with dignity with what must otherwise be a dangerous foe.

It would be out of place to argue against the possibility of mental cures. Thousands of such instances are upon authentic record and it would be idle to deny the power of the mind over the body. There is no question that certain diseases have been cured by believers in faith cure, in prayer cure, in every phase of this theory that can be imagined. There is such a healer near my home, who has hundreds of patients, from near and from far they come, and I do not doubt that some are cured, and to a rational thinker there is no mystery about the process, but the fact remains that the process cannot be rationally explained, so that the subjects of it can clearly understand it. Consequently in endeaving to maintain our professional self-respect, we are in danger of actually becoming illiberal, narrow-minded and dogmatic.

The importance of some definite restraining force for these abuses can scarcely be overstimated, and if the public opinion and the advanced philosophical science of our era have been powerless to effect this, it would seem to come into the province of legislative enactment.

PRESIDENT'S ADDRESS.

Delivered Before the Pennsylvania and Maryland Union Medical Association at Chickies' Park, Columbia, Pa., August 30, 1894.

By Levi Frey, M. D.,
York, Pa.

Ladies and Gentlemen:—I greet you cordially and bid you all a hearty welcome to our reunion, hoping we may spend the day pleasantly and carry to our homes happy memories of this social intercourse. And in order to make the social side of our meeting the prominent one I will say that I shall take the liberty of departing from our customary rule and instead of inflicting upon you what I fear would prove a tedious and uninteresting part of our exercises I in place of the formally prepared president's address speak very briefly of Doctors' Social Meetings in general and make a few references to the Pennsylvania and Maryland Union Medical Association in particular.

Such meetings as this of to-day have a tendency to make us better acquainted with each other and are the means of establishing new friendships and strengthening those already formed. They create a sympathy for each other among the members of our hard-worked profession and show us the better side of our nature, calling forth that which is estimable and teaching us to overlook and forget that which we are only too prone to think wrong.

No class of men, much less intelligent and cultivated men, can meet under such circumstances as we meet to-day, sit around one common table and break bread with each other without having some of the asperities of life rubbed out and their regard for each other strengthened.

These meetings are the means of breaking down the barriers that have stood and still exist to too great a degree between some of our best men, removing that jealousy, suspicion and envy which has prevented them from working in harmony with each other in their efforts to ameliorate human woe and suffering. To illustrate this truth, for truth I take it to be, I heard one of my friends from your city just at our feet, express himself, to my surprise, that he often wondered what had become of, or why he could never meet one of the leading physicians and surgeons, who has laid off his harness many years ago and passed over to that world where doctors are not needed. Now this deplorable example of a want of intercourse and knowledge of each other could not have existed if our annual reunions of the Pennsylvania and Maryland Medical Association had then prevailed.

And now as to the influences of our Association. Should it disband to-day, it could claim our lasting gratitude and kindest memories for what it has already accomplished. This Association and the Lancaster County and City Medical Society have been the channels through and by which close, strong, and we trust, lasting friendships have been formed. They have drawn the mother and daughters (Lancaster and York) into closer intimacy and sympathy than existed between them until within a very recent period. So little knowledge did we of York have of the Lancaster county physicians and they of us that in case of sojourning in our respective cities we should scarcely have been able to find a brother of the profession upon whom we should have felt free call or with whom we could have spent a little season of unrestrained intercourse.

But how different now. As already said the warmest friendships have sprung up between the members of the respective societies. We of York have already captured your industrious and scientific Ziegler, your irrepressible Craig, one of your foremost surgeons, your Livingstone, gentlemen and intelligent physicians, your manly and well beloved

Deaver, whose sudden and unexpected death we cannot yet cease to lament. All these we hold as of our own society. They frequently attend our meetings, vote on all questions as honorary members, speak upon all questions and add much to the interest and profit of our transactions. The veteran Ziegler has entertained us with admirable talks and exhibited to us some of his finest microscopical specimens. Craig has given good advice in medico-legal matters and all have given us pleasure by their presence.

Then, again, what delightful days we have spent at the annual banquet of the County and City Medical Society in the venerable city of Lancaster, and in an especial manner at your semi-centennial. There we listened with pleasure to the eloquent and pathetic paper of the excellent physician Ziegler, on the rise, progress and present status of the Lancaster County and City Medical Society.

There and then we met and associated with the genial and indomitable Welchans, capital toast-master, the scholarly Ulrich, the wide-minded Weidman, the reputable physician Rauch, since passed to his reward, and last, but by no means least, there we were permitted to look into the faces and listen to the eloquent words of the professional magnates from our centre of medical knowledge.

But pardon the omission in these references to the personnel of these meetings. I must not forget our friend and fellow member, Dr. John Morris of Baltimore, whose genial manner and pleasant talks have added so much to our pleasure on such occasions.

One other thought concerning the influences of these society reunions. They draw the line between the regular and intelligent physician and the irregular, more sharply. The charlatan does not fraternize warmly with the regularly graduated and honest, conscientious physician. Like oil and water or like spurious coin, they do not mix or give the right ring. The pretender is out of his element here and feels it. He fears that he may be known as a stray sheep who has not entered by the right door, whose very manner and words betray him as one who thrives upon a credulous public and by an assumed knowledge he does not possess.

These are some of the chief reasons why we should hail these reunions as red-letter days and mile-stones along the thorny path of the hard-worked and often unrequited doctor, beckoning him on in his journey through life and encouraging him in his daily conflict with fell disease.

Let us then get all the social pleasure we possibly can from these days out of school. In these times of change and progress in our profession, when we have medical literature *ad infinitum* and new drugs *ad nauseam*, let us see to it that we also have social pleasures *ad libitum*.

Now, in conclusion, a few words to the ladies: Your presence here cheers us and adds much to our pleasure. Our social meetings would lack much without you. There is no class of men with better wives than doctors, and no class of women with better husbands than doctors' wives, and believing this to be so, I commit the comfort and welfare of these doctor husbands, sons and brothers, into your hands, knowing full well that in trouble you will stand by their side, in disappointment and failure you will encourage them, in sickness you will watch by their bed-side and smooth their pillow and cool their fevered brow, and in return for this they in time of distress will risk comfort, health, and even life, for your welfare.

To the ladies of the Guild we would say well-done, for you have succeeded admirably in catering to the fastidious and capricious appetites of those who were so fortunate as to partake of your toothsome viands and who, somebody says, did "eat much and talk little."

Vulvitis Pruriginosa.—Sänger, in the *British Medical Journal*, believes that this disease arises from the most varied causes, not excluding auto-intoxication of intestinal origin, most frequent in the subjects of chronic constipation. In most cases of vulvitis pruriginosa direct local treatment proves successful.

SOCIETY REPORTS.

BALTIMORE MEDICAL ASSOCIATION.

MEETING HELD FEBRUARY 26, 1894.

Dr. H. H. Biedler, Vice-President, in the chair.

Dr. David Streett spoke of finding INDICAN IN THE URINE. Although regarded as rare, he generally finds it during convalescence from scarlatina. It shows intestinal indigestion. It is found in the urine of nearly all persons suffering with any form of intestinal disorder. Osler says that it is generally found when a milk diet is given. This may account for its occurrence in scarlatina.

Dr. John T. King asked if the blue color ever occurs before the addition of hydrochloric acid. Not long ago he was called to see a young lady who had passed urine of the color of a solution of sulphate of copper. He first thought that something in the vessel had caused it, but investigation proved not.

Dr. Streett thought it was free indican.

Dr. John Morris had had no experience in this line. He had seen urine colored from other causes.

Dr. E. G. Waters asked Dr. King if the urine in his case contained albumen. Was she suffering with any chronic trouble; to which Dr. King answered, No.

Dr. H. H. Biedler reported a case of FOREIGN BODY IN FEMALE BLADDER. Such bodies are not uncommon. We often find hairpins, etc., in the female bladder. Three classes of cases, bodies entering through perforation, forming in the bladder, and entering through urethra. His patient was a mulatto who had said to another physician that she had tried to bring on menstruation by introducing a lead pencil into the bladder, but she told Dr. Biedler that she could not urinate and tried to overcome that difficulty by putting a pencil into the bladder. The pencil had been in that organ twelve or fourteen days before she came to him. There were the usual symptoms of foreign bodies in the bladder. Some days she could pass her urine and sometimes she could not. Examination revealed foreign body in the bladder. He anesthetized the patient and dilated the urethra. She had no blood in her urine. The lead in the pencil was dissolved by the acid in the urine. The pencil was removed with alligator forceps assisted by index finger. The pencil was divided.

Dr. John Morris: These foreign bodies sometimes serve as nuclei for calculi.

Dr. E. G. Waters: Dr. Biedler is right in his explanation of the solution of the plumbago in the pencil.

Dr. Biedler: We have no right to put a hypothetical construction upon a case. This is a very interesting subject to the general practitioner. After the pencil had been in the bladder some days the plumbago was dissolved and the sides of the pencil were separated. Then irritation was set up and a frequent desire to urinate was the result. Then muscular contraction brought the sides of the pencil together again. It was removed with much difficulty. There was slight irritative fever followed by entire recovery.

Dr. J. T. King reported two cases of DILATATION OF THE STOMACH. (See page 417.)

Dr. Streett asked if there were any obstruction in his first, the functional case.

Dr. King replied that the post-mortem was made in the West. The physician who made it assured him that there was not.

Dr. Biedler asked if emaciation were marked and if there were any history of syphilis. Dilatation of the stomach is a rare affection.

Dr. Streett asked if there were free hydrochloric acid in his cases.

Dr. King replied that this point was submitted to Dr. N. G. Keirle, but he had not received a report. Some authorities say that this affection is more common than we suppose. There was no history of syphilis.

Dr. Streett: It is unquestionably correct to say that dilatation of the stomach is a relative term. If the post-mortem was carefully made, Dr. King's first case was most probably functional. It may

have been caused by excessive eating long continued. Some cases of dilatation of the stomach have what the Germans call a sling shape. In that case, even though the patient were not a hearty eater, there would be difficulty in getting food out of the stomach.

Dr. King had nothing further to say except that he did not speak of the pathological features, thinking that Dr. Chambers would exhibit the specimens. Vomiting occurs after food has been in the stomach some time. There is one case on record of floating kidney caused by tight corset, producing dilatation of the stomach.

EUGENE LEE CRUTCHFIELD, M. D.,
Recording and Reporting Secretary.

PENNSYLVANIA AND MARYLAND UNION MEDICAL ASSOCIATION.

HELD AT CHICKIES' PARK, COLUMBIA, PA., AUGUST 30, 1894.

THE Society met at noon under the auspices of the following officers: President, Dr. Levi Frey, York; Secretary, Dr. D. K. Gotwald, York; Treasurer, Dr. Geo. W. Stump, Perryville; Executive Committee, Drs. Alex. Craig, chairman, George W. Gillespie, A. C. Wentz, R. E. Brommell, J. Reilly Bucher, W. M. Weidman and H. A. Hare. The following physicians were present. From Pennsylvania: Lebanon, Drs. W. M. Gilford, J. Reilly Bucher; Mount Joy, Drs. J. L. Ziegler, J. P. Ziegler; Maytown, Dr. G. A. Harter; York, Drs. Levi Frey, W. F. Bacon, I. C. Gable, J. Frank Small, Jacob R. Spangler, D. K. Gotwald; Letort, Dr. J. K. Mowery; New Providence, Dr. William J. Wentz; Pittsburg, Dr. W. S. Foster; Pleasant Grove, Dr. G. W. Gillespie; Harrisburg, Drs. M. M. Ritchie, J. Landis Seitz; Lancaster, Drs. George R. Welchans, George R. Rohrer, M. L. Davis, C. E. Netscher; Lampeter, Dr. J. H. Musser; Annville, Dr. J. William Trabert; Manchester, Dr. J. Strickler Quickel; Mountville, Dr. J. R. Lehman; Hanover, Dr. A. C. Wentz; Hamburg, Dr. J. B. Potteiger; Oxford, Drs. Lewis H. Kirk, Frank Gillespie; Chester, Drs. W. B. Ulrich, H. von Stoerer; Marietta, Drs. H. M. Alexander, H. A. Mowery; Steelton, Dr. N. J. Middleton; Reading, Drs. W. Murray Weidman, Israel Cleaver, Henry Landis; Bird-in-Hand, A. M. Miller; Leaman Place, Dr. B. Leaman; Philadelphia, Dr. Thomas S. K. Morton; Bethesda, Dr. J. F. Yost; Strasburg, Dr. H. M. Black; Germantown, Dr. J. R. Shellenberger; Columbia, Drs. Alex. Craig, T. M. Livingston, C. F. Markel, A. R. Craig, S. A. Bockius, J. K. Lineaweaver, S. M. Crawford, G. W. Berntheisel, J. B. McBride. Maryland: Baltimore, Drs. Rohé, John Morris; Port Deposit, Dr. R. E. Bromwell; Rising Sun, Dr. George S. Dare; Elkton, Dr. John H. Jamar.

The morning's program included a reception at the park, and dancing. At noon all the visitors and friends were brought to Columbia on special cars, to partake of a banquet in St. Paul's Parish building, provided by the ladies of St. Paul's Guild. Covers were laid for 140 persons. The tables were handsomely decorated with flowers. The menu included deviled crabs, spring chicken, cold meats, coffee, ice cream, cakes, fruits, etc. It was promptly and skilfully served, and was thoroughly enjoyed by everybody present. At the close of the feast, Dr. Craig rapped attention, and introduced Dr. Frey of York, who made the President's Address (see page 424).

Dr. Frey was followed by Dr. Weidman of Reading, president of the Lehigh Medical Association, who, after expressing his preasure in being here, referred briefly to his own society. He was followed by Dr. John Morris of Baltimore, who made a very forcible speech. He admitted, however, that the only place where wisdom is disseminated is at an editorial banquet. He pleasantly referred to the travels of Dr. Craig into the heart of the Andes, and of Dr. Rohé into the heart of Europe, to learn all about that "new-fangled disease, appendicitis."

Dr. Rohé followed with an appendix(!) to the Baltimore contingent, and made an entertaining speech. Other speakers

were Dr. Foster of Pittsburg, Dr. Jamar of Elkton, and others. Dr. Craig made an admirable toastmaster, and supplied the oratorical music between the speeches, while the musicians rested and ate their dinners.

At the conclusion of the banquet and speeches the following officers for next year were elected: President, Dr. G. H. Rohé, Baltimore; Vice Presidents, Dr. S. A. Worrall, Cecil Co., Md., Dr. J. R. Shellenberger, Germantown, Pa.; Secretary and Treasurer, Dr. J. K. Lineweaver, Columbus, Pa.; Executive Committee, Drs. Alex. Craig, chairman; A. C. Wentz, Hanover, York Co., Pa.; J. H. Jamar, Elkton; J. R. Bucher, Lebanon; W. M. Weidman, Reading; Edward Jackson, Philadelphia; Frank Gillespie, Oxford.

CORRESPONDENCE.

HYDROPHOBIA—STATISTICS DESIRED.

PHILADELPHIA, PA.,
Sept. 1, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—Will you permit me, through your columns, to ask that my professional brethren will communicate to me the occurrence of cases of so-called hydrophobia in their practice for the year 1894, from January 1, and so on until the end of this year?

I would like in all cases to learn:—1. The sex and age of patient. 2. (*a*) The kind of animal that is credited with the inoculation; (*b*) Its state of health; (*c*) The provocation to bite (if any existed); (*d*) The reasons why the animal was (if it was) deemed rabid; 3. The seat of the bite (or other mode of inoculation). 4. The fact and method of cauterization (if any). 5. The time between the inoculation and the outbreak. 6. The symptoms of the outbreak, the occurrence of mania or imitation of dog actions. 7. The remedies used and doses, with their seeming effect. 8. The issue of the case and when death occurred. 9. The investigations made to exclude the presence of disease other than so-called hydrophobia. 10. The findings on autopsy, if one was held.

I shall, of course, acknowledge in future publications aid received in continuing my studies in regard to this subject.

Yours truly,
CHARLES W. DULLES, M. D.
4101 Walnut Street.

MEDICAL PROGRESS.

CONGENITAL TUBERCULOSIS. — Lehmann (*British Medical Journal*) relates a further case. A phthisical woman, aged 40, gave birth to a child and died three days later from tuberculous meningitis. The child died twenty-four hours after birth. In its liver, spleen, and lungs nodules were found exactly resembling tubercle. Tubercle bacilli were also present in large numbers. The tuberculous lesion was more advanced in the mesenteric and bronchial glands. The placenta was unfortunately not examined. The tuberculous affection was assuredly intrauterine in origin. The question as to whether the generalized tuberculosis was disseminated from the glands which contained the oldest lesion or whether it was a new infection from the mother, could not be decided. A direct passing over of tubercle bacilli from the mother's to the infant's blood does not appear probable. The rupture of a tuberculous focus in the placenta into the fetal circulation is possible.

* * *

THE FORCEPS IN DELIVERY.—Schmid (*British Medical Journal*) publishes important statistics from the Bâle Lying-in Hospital. Out of 2926 women confined between May, 1887, and the end of December, 1893, 156 (5.33 per cent.) were delivered with forceps; 83.3 per cent. were primiparæ. In only 13 cases was the head arrested high in the pelvis. Presentation in the second cranial position more frequently required the forceps than the first position, whilst still more often instrumental aid was necessary in frontal and brow presentations. The medium loss of blood after delivery was 591 grammes, the maximum being but little higher. In 132 cases (84 per cent.)

the perineum was injured, and was sewn up at once, union by first intention occurring in 92 per cent. In 7 cases the os was widened by incision. The total maternity mortality was 1.28 per cent., but not one woman died from the results of the application of the forceps. In 118 of the 156 cases there was no rise of temperature in childbed. The infantile mortality was 10.2 per cent., 5.7 per cent. being lost through the result of the application of instruments; 131 were discharged alive. Schmid strongly favors the use of forceps. It is as a rule neither dangerous to mother or child. The flooding is due to atony of the uterus, and is seldom due to injury by the instrument. Injuries to the perineum should be sewn up whether they bleed or not, and the wounded surfaces have a tendency to unite. Feeble pains and consequent prolongation of the labor are indications for the use of the forceps when the head is in a proper position for its application, and the second stage has lasted over two hours and a-half. In no case should over four hours be allowed to elapse. The long forceps should only be used by experienced hands, and for the safe delivery of the child when its life is endangered.

* * *

Enteralgia.—Heinrich Stein (*British Medical Journal*) advocates with Bamberger the use of the term "enteralgia" for those cases of intestinal colic depending on a functional disturbance or neurosis, confining the term to those conditions in which the nerves only are affected. Enteralgia is met with in so-called cases of nervous diarrhœa, in the affection formerly termed "enteritis membranacea," but now held to be a functional disturbance; in toxemia, the result of lead, etc.; in gout and malaria. The pain itself usually comes on spasmodically, without apparent cause, and is of variable duration. Its character and the description given vary, but it is usually referred to the umbilical area, and the abdominal wall is retracted. The treatment is often difficult; drastic purgatives should not, however, be given, but a condition of rest should rather be aimed at. Constipation should be counteracted by enemata, oils, or small doses of calomel, and a quiet state of the bowel may be produced by means of high temperatures, strong electric currents, alcohol, opiates, chloral, or atropine. The general condition of irritability requires bromides and tonic treatment.

* * *

A New Operation for Hernia.—The fertility of the surgeon's brain in suggesting new operations or new methods in old operations for hernia seem well nigh inexhaustible. Dr. A. M. Phelps says that relapses in oblique hernia takes place at the internal abdominal ring and he gives his opinion in the New York *Medical Record* that our efforts to prevent relapse should be directed particularly to the internal abdominal ring to make this part of the inguinal canal as strong as possible, to obliterate the canal and to form an artificial inguinal canal for the cord external to the muscles. To carry out these ideas as far as possible and correct the errors that have led to failure he explains his method very carefully and relates cases treated by him. His conclusions from his work are:

1. That relapses occurring in hernia are due to the improper way of treating the sac.

2. The use of catgut and other absorbable materials in the closing of the abdominal parietes.

3. The improper treatment of the inguinal canal.

4. The dimpling produced in the peritoneum to the ligation of the sac externally.

To remedy these causes of relapsing in hernia:

1. The sac should always be either cut off and ligated within the peritoneal cavity;

2. Puckered together and inverted into the abdominal cavity; or

3. Inverted into the abdominal cavity and drawn up well behind the abdominal wall.

4. The inguinal canal entirely obliterated by being stitched up with fine silver wire.

5. Changing the inguinal canal by

bringing the cord out through the different layers of muscles at different points, thus making one layer of muscle act as a guard against the opening in the layer underneath.

6. In large openings and in relapsed hernia, the introduction of wire loops, as already described. *Strangulation of the sac when treated in this manner never occurs, because the circulation is not interfered with.* When the stump of the sac, however, is ligated in the peritoneal cavity, it unites with the adjacent tissue precisely as the stump does following an ovariotomy.

* * *

The Ulnar Phenomenon.—Cramer (*British Medical Journal*) gives an account of the morbid anatomy of a case of general paralysis, in which there was marked analgesia of the trunk of the ulnar nerve on the left side, whereas the reflex was present on the right. He has previously shown that this ulnar symptom is absent in the great majority of general paralytics, and mostly present in other insane persons, so that he would look upon it as of some diagnostic value. The ulnar nerves, as well as the spinal cord and brain, were carefully examined in the above-named case, and yet no changes were found to explain the phenomenon. The spinal meninges and extrapial roots were also intact. The author thinks that the exact localization of ulnar analgesia is rarely possible, but that it is more likely to be due to the general widespread changes found in the nervous system.

* * *

Uremia.—The Boylston Prize for 1893 was awarded to Drs. William E. Hughes and William J. Carter, for their very thorough clinical and experimental study of uremia, which runs through two numbers of the *American Journal of the Medical Sciences.* This study verifies the clinical fact that milk is the best food in cases of uremia. The authors' conclusions from their work are:

1. Uremia is an intoxication by a poison circulating in the blood.

2. This poison is present in serous effusions as well as in the blood.

3. It is probable that in addition to the pathogenic poison of uremia there are, under certain conditions, other secondary ones active in its production.

4. The poison producing uremia will also produce nephritis and a fatty degeneration of the retina, the cause of the eye symptoms in Bright's disease.

5. This poison is probably some albuminous substance. It is affected by heat and is only with difficulty dialyzable.

6. It is probable, but not certain, that this poison is not constantly circulating in the blood, but that under exceptional conditions it becomes developed.

7. It is possible to have uremia without any previously existing lesion in the kidneys.

* * *

Early Syphilitic Glycosuria.—M. A. Tchistiakoff (*British Medical Journal*) describes in detail an instance of glycosuria occurring in the early stage of syphilis, and rapidly disappearing under the influence of the usual antisyphilitic treatment. Reviewing similiar cases recorded in literature (Seegen, Servantie, etc.), he comes to the conclusion that in the course of the secondary incubation stage of syphilis there may sometimes develop glycosuria of a benign nature which is characterized by the following clinical features: (*a*) the daily amount of sugar in the urine remains scanty; (*b*) the daily quantity of the urine does not undergo any considerable increase; (*c*) beyond the presence of sugar, the composition of the urine does not show any marked deviation from the normal standard; (*d*) increase of thirst and appetite and emaciation occur within fairly moderate limits; and (*e*) the disturbance is of a more or less fleeting nature, and may subside spontaneously after the eruption of initial cutaneous syphilis. The glycosuria seems to constitute a manifestation and result of a perverted tissue metabolism arising in the earlier period of syphilis.

* * *

Extraction of the Lens in High Degrees of Myopia.—Vacher (*British Medical Journal*) gives the results of

his treatment of progressive myopia of high degree by removal of the lens. The cases were twenty-one in number; before operation there was myopia of 14 D or more in all but three patients, in whom the lens was becoming cataractous; in all of them there was complaint of pain, headache, inability to see to read or work, and photopsiæ. The visual acuteness after the operation remained stationary, or improved somewhat, but the myopia showed no tendency to increase, while on the other myopic eye of the same patients, which had not been operated on, it still progressed slowly. On the contrary, careful examination of the refraction at intervals showed that extraction of the lens tended to favor or provoke a slight decrease in refraction of the eye in addition to that produced by the removal of the lens itself.

* * *

Flat-foot and Metatarsalgia.—Dr. Joel E. Goldthwait contributes to the *Boston Medical and Surgical Journal* an article on the obliteration of the anterior transverse arch of the foot as a cause of metatarsalgia, from which he draws the following conclusions:

At the metatarso-phalangeal articulations there is an arch, called by the writer the anterior-transverse arch. This, at times, becomes flattened, and symptoms develop which are characteristic.

The symptoms most commonly met with are pain, referred to the anterior portion of the foot—the so-called anterior metatarsalgia—and the presence of a painful callous in the centre of the ball of the foot.

The impression of the foot is typical, and can be developed in many cases, even when the longitudinal arch also is obliterated.

The treatment consists in the restoration of the arch by plates, pads or bandaging.

* * *

Multiple Cesarean Section.—Guéniot (*British Medical Journal*) exhibited recently at a meeting of the Académie de Médecine two rachitic women on each of whom he had performed Cesarean section twice. One, E. R., was a dwarf little over 3 ft. 8 in. high; the conjugate diameter of the pelvis hardly exceeded an inch and a half. In the other, J. N., the pelvis was about equally deformed. The second pregnancy was almost coincident in both. The first section occured in J. N. on January 14, 1891, in E. R. on December 17, 1892. J. N.'s child, a girl, is now living and healthy. E. R.'s, also a girl, was exhibited when 6 weeks old, as showing evidence of congenital rickets. The second Cesarean section was performed on J. N. on May 21, 1894, on E. R. on May 28. Both infants were males, and were alive on July 3. E. R.'s baby, like its sister, had congenital rickets. Guéniot objects to Porro's operation, and to ligature of the tubes. In 1891 he performed section on a woman badly afflicted with mollities. He left uterus and appendages alone; the child lived. The bone disease never progressed. On June 13, 1893, he delivered the mother by aid of symphysiotomy, and saved her and her child.

* * *

Sewer-Gas and Throat Disease.—Sewer-gas as a subject for discussion has attracted much attention of late, both in this country and in Europe. Theorists would have us believe that it is free from all organisms, and not an unwholesome compound. There are, however, some practical men who see the connection between the exposure to sewer-gas and disease, and this is instanced in Dr. Beverley Robinson's conclusions in the New York *Medical Record* as to the influence of sewer-gas upon disease of the throat. He says:

1. Given a patient with a so-called weak throat, subject to frequent attacks of quinsy, etc., expose him to sewer-gas, he will probably develop amygdalitis.

2. Given a patient in good health, with a throat containing Klebs Loeffler bacilli, expose him for any time to sewer-gas, and he will probably develop diphtheria.

3. Given a mild case of diphtheria, expose him to sewer-gas, and the disease will assume a more malignant type.

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See Publishers' Department, Page 436.

BALTIMORE, SEPTEMBER 15, 1894.

Elimination of Ether.

THE comparative effect of chloroform and ether inhalations are familar to most physicians who have had experience in anesthetizing. It has long since been proved clinically that it is dangerous to administer ether to a person with kidney or lung disease. In regard to the former organ Dr. George B. Wood has made an elaborate study in the *University Medical Magazine.*

He says it has never been conclusively proven that the kidneys excrete ether, yet it seems very probable that if ether exists in the blood in the free state the kidneys will try to get rid of it. Experiments on dogs enabled him to detect ether in the blood by the odor, but from examination of the urine of patients who had just undergone etherization in the hospital he concludes that ether is not eliminated by the kidneys, but by the lungs.

Experiments on dogs would show that ether is a decided irritant to the kidneys and his summary from his work is thus given :

1. As regards the relation of ether to the healthy kidney. It has been proved that ether exists as such in the free state in the blood, and yet coming as it must in close relation with the kidney, it is, contrary to previous opinions, not excreted by that organ to any appreciable amount. Nevertheless, it has been demonstrated that in ether anesthesia the kidney becomes congested, and on microscopical examination the cells show cloudy swelling. The cells of the convoluted tubules are primarily affected, the tufts and collecting tubules only evincing change when the anesthesia had been prolonged. Repeated administrations of ether, if kept up long enough, would probably cause desquamation of the epithelial cells.

2. As regards the diseased kidney. The local effect of ether must be very deleterious to an already diseased kidney, for any unhealthy organ will not stand wear and tear like a normal one. In cases where uremic poisoning was commencing to make itself apparent, it was shown that there existed a liability to sudden death during ether narcosis, due to the action of ether on the already depressed centers of respiration.

*

An Enteric Pill.

A PILL that will pass through the stomach unchanged and expend its action on the intestines is what certain therapeutists have been long seeking. Dr. Louis Waldstein describes in the *New York Medical Journal* an enteric pill which he considers fairly satisfactory, although his investigations have not been brought quite to completion. The idea is to be able to administer certain substances protected from the action of the stomach juices and which shall neutralize or destroy in a chemical sense those soluble toxic principles (ptomaines) in the intestines. Unna's coating did not last, but cracked, and after a long experimenting, assisted by competent druggists, Dr. Waldstein found the best coating to be a mixture of shellac and salol dissolved in alcohol. He gave pills of methylene blue covered with his coating and they were undissolved by the gastric juices, while the feces and urine passed were quite moderately colored. The author suggests treating typhoid fever with pills coated in this way and he also has used pills containing extractum pancreatis and bicarbonate of soda in diabetes. The idea of making enteric pills, which is not original with the author, as he

says, needs the test of experience before anything can be said of its value. Such a method, honestly tried, may lead to better results in certain putrefactive intestinal diseases.

* * *

THIS great country is so broad and extensive that it is no wonder if one code of ethics or rules of behavior should not suit all persons alike. The worthy editor of the *Texas Health Journal*, whose letters from abroad this summer have been read with great interest, comes out with a card in his journal to the profession of his State, announcing that he has spent several months in Europe perfecting himself in his specialty and has purchased instruments and apparatus regardless of price at a cost of nearly two thousand dollars. He asks the general practitioners to send him the cases they do not understand and then adds, "I will make it especially advantageous to every physician who kindly refers patients to me for treatment; try and see if I do not; a hint to the wise is sufficient." He further says that he will treat any member of a physician's family absolutely free, or any charity case referred to him by a physician. His large paying practice enables him to do this and besides the pleasure of curing those unable to pay is sufficient remuneration for him. This is evidently stated in all honesty and openness of purpose and yet there is a certain naïveté about it that makes those in the effete East smile. He deserves all the cases he gets and he will undoubtedly treat them well.

The Code of Ethics

* * *

GONORRHEA is not a desirable disease and in many cases it is more disastrous in its complications and results than syphilis. Still there are thousands of men who go through a course of this trouble with a few bottles of sandal wood and an injection, the formula of which they always carry with them for immediate use. We should then hardly be justified in giving what Dr. Burnside Foster calls, in the *Journal of Cutaneous and Genito-Urinary Diseases*, the ideal treatment of this disease.

He suggests that immediately after the attack the patient should be etherized, properly prepared, a buttonhole opening made in the perineum and drainage of the bladder be established; and at the same time the urethra could be flushed from behind. He believes cases of clap could thus be cured quickly and finally. After describing the operation, he then ingenuously adds that he has never had an opportunity to adopt this method, and his patients probably hope that he never will. It only shows how far apart are theory and practice when a man suggests an operation that he has never tried or has never heard of.

Theories in Surgical Operations.

If a new operation of any kind be suggested, it should first be tried on the cadaver and then on an animal and then if the preliminary parts be clear, a case in hospital where the consent of the patient has been obtained may be tried and then further cases until a sufficient number has been recorded to draw valuable conclusions, and then a description of the operation with reports of cases and proportions of successes and failures would have some weight.

The proposing of such theories in surgery is radically wrong, for it is often a wild fancy on the part of an ingenious but not practical brain that may lead others equally unpractical but not ingenious to commit a surgical sin and perform needless experiments on the patient.

* * *

AS TEA is one of the principal articles given to the poor by charitable societies, Dr. James Wood, a Brooklyn dispensary physician, seeks to point out in the *American Medico-Surgical Bulletin* the evils of immoderate tea drinking and how prevalent tea tippling is among the poor. Of course, as far as the injurious effects are concerned, the writer tells us very little that is new, but in his capacity as physician to the poor, the fact that excessive tea drinking is a prominent cause of much of the illness is brought to him very forcibly.

Evils of Tea Drinking.

Two-thirds of these tea drinkers are women who, hard worked and tired out, seek stimulation in tea and keep a tea pot simmering on the stove all day long. The consequence is they have headaches, indigestion and a long array of disorders, principally nervous, as the result. If our good people would not be so lavish with tea distribution, it is evident that the dispensary would not have so much to do and sickness would not be so common. When persons are poor, cold and underfed, it is very much harder to resist drinking, whether it be tea or whiskey.

MEDICAL ITEMS.

Dr. A. D. McConachie has returned from Europe.

A Medical School for women is about to be established in St. Petersburg.

Dr. John Guitéras is investigating the reported cases of yellow fever in Baltimore.

It is very likely that the case of cholera reported at Cumberland last week was Asiatic.

Dr. Charles O'Donovan, who was reported to be ill with appendicitis in Boston, has recovered.

The nurses of Detroit have followed the example of the nurses of Baltimore by opening a house and registration office of their own.

Dr. Charles H. Williams, Ex-Surgeon United States Army, died in Washington last Monday. Dr. Williams was a graduate of the University of Pennsylvania.

The Faculty of the Baltimore Medical College took possession this week of the new Maryland General Hospital. The facilities of this school are said to be very good.

Several cases of yellow fever found their way into the city last week, from a vessel from the South. No new cases have developed and it is too late in the season to fear a spread of the disease.

Dr. Larkin W. Glazebrook of Washington, D. C., has been appointed Deputy Coroner for the District of Columbia; and, under a recent Act of Congress, is authorized to assume all the duties of the Coroner in his absence.

From the University of Pennsylvania the following graduates have been appointed, after competitive examination, internes in Baltimore hospitals. Dr. A. Preston Miller, Maryland General Hospital, Dr. William M. Cousins, Johns Hopkins Hospital.

Dr. Juan J. Ulloa of Costa Rica, has been appointed Secretary of State in the Department of the Interior and of Public Improvements of Costa Rica. Dr. Ulloa was a delegate from Costa Rica to the Pan-American Medical Congress, and is a graduate of the medical department of the University of the City of New York.

The National Medical Review of Washington, D.C., says that Congress gives $12,000 for the Emergency Hospital; or an addition to Columbia Hospital, $10,000; for the National Homeopathic Hospital, $8000; and $4000 to enforce the provisions of the act to prevent the spread of scarlet fever and diphtheria in the District.

The anti-vaccinationists in Brooklyn have been waging war against the health authorities in that city with varying success, but have been worsted in their latest contest relating to public schools. Under the recent decision of Justice Bartlett of the Supreme Court, the principals are empowered to reject all pupils who cannot produce certificates that they have been vaccinated.

A most distressing accident occurred last week in Baltimore, which resulted in the death of Dr. Basil J. Shorb. Dr. Shorb was crossing the street in a heavy thunder storm, when an electric car ran over him, inflicting injuries which proved fatal. Dr. Shorb was graduated from the University of Maryland in 1889, and was a member of the various local and State societies. He was at one time resident physician at the Woman's Hospital.

At the Eighth Annual Meeting of the American Association of Genito-Urinary Surgeons held at Washington, D. C., in May, the following officers were elected for the ensuing year: President, Dr. D. Bolton Bangs of New York; Vice-President, Dr. Francis S. Watson of Boston; Secretary and Treasurer, Dr. W. K. Otis of New York; Member of Council-at-Large, Dr. J. A. Fordyce of New York. It was decided to hold the next meeting of the Association at the Clifton House, Niagara Falls, during the last week in May, 1895.

The announcement of the death of Herman von Helmholtz last week in Berlin was not a surprise. Herman Ludwig Ferdinand von Helmholtz was born in Potsdam in 1821 and early showed a fondness for the study of medicine. He was an assistant at the Charité Hospital at the same time with Virchow and the two remained fast friends to the end. Helmholtz engaged in active practice a few years, but busied himself more with physiological work in the department of sight, light and sound. He invented the ophthalmoscope and was the author of many of the theories on sound which are accepted at the present day. He was actively engaged in work up to the last few years of his life and no later than last year he visited this country and attended the electrical congress at Chicago. One son follows in his footsteps.

BOOK REVIEWS.

AN ILLUSTRATED DICTIONARY OF MEDICINE, BIOLOGY AND ALLIED SCIENCES; Including the Pronunciation, Accentuation, Derivation and Definition of the Terms used in Medicine, Anatomy, Surgery, Obstetrics, Gynecology, Therapeutics, Materia Medica, Pathology, Dermatology, Pediatrics, Ophthalmology, Otology, Laryngology, Physiology, Neurology, Histology, Toxicology, Dietetics, Legal Medicine, Psychology, Climatology, etc., and the Various Sciences closely allied to Medicine: Bacteriology, Parasitology, Microscopy, Botany, Zoology, Dentistry, Pharmacy, Chemistry, Hygiene, Electricity, Veterinary Medicine, etc. By George M. Gould, A. M., M. D. Based upon Recent Scientific Literature. Philadelphia: P. Blakiston, Son & Co., 1894. Pp. xvi-17 to 1633.

It is not easy to criticize carefully a book as large and as complete as this. In two months' constant use no errors have yet been found. One great value of the work is its convenient size and its inexhaustible contents. No words seem wanting. Every possible definition and combination are given and yet the work is not too clumsy for ordinary use. As long as we have no fixed standard for spelling and pronunciation and in the absence of an Academy, each reformer will follow his own method as Dr. Gould has done. The final "ic" at the end of some words looks like an incomplete amputation. As a critic has recently said: "Will the 'medic' profession adopt this new orthography ?"

The illustrations are numerous and excellent and the complete tables are not only a credit to the hard-working author but are a marvel of the printer's art. Some definitions amount almost to dissertations. The derivation and pronunciation of each word is given. There may be faults in this great work but it would take time to find them. The publishers have certainly excelled their usual good work in this book.

REPRINTS, ETC., RECEIVED.

Fifth Annual Announcement of the Kansas Medical College, Topeka, Kansas. Session, 1894-95.

A Report on Orificial Surgery. Based on an Analysis of 1000 Cases Prepared for the World's Congress of Homeopathic Physicians and Surgeons, Assembled in Chicago, May 29, 1893. By E. H. Pratt, M. D., LL. D., Chicago. Reprint from the *Journal of Orificial Surgery*.

CURRENT EDITORIAL COMMENT.

TUBERCULOSIS.

American Medico-Surgical Bulletin.

WHILE it may be hard for the lay mind, in fact for some within the ranks of the medical profession, to give up the old theory that tuberculosis is inherited as a disease *per se*, it is nevertheless the duty of the profession, acting as the true guardians of the public health and welfare, to bow gracefully to scientific advance and to accept the undeniable facts as they are announced by those who have the skill and the opportunity to establish the fundamental truths in relation to the etiological factors of disease.

MEDICAL PRACTICE.

Medical and Surgical Reporter.

ALL medical practice is based upon certain theories, these theories are constantly undergoing modifications under a changing and better light. Many an old hypothesis through the force of its absurdity has been pushed to the wall. The effort of modern teaching is to remove medical and surgical theories as far as possible from all error. In late years the changes in operative appliances and methods have been numerous, and both medicine and surgery have grown more and more to be affairs of science. The processes of this growth are infinite—the end will never be reached.

ATHLETES AS INSURANCE RISKS.

The Medical Examiner.

IN insurance we have always been led to suppose that athletes are poor risks. At any rate it is the practice of companies to consider them as poor risks until they have been proved to be good risks. That is to say, athletes, either professional or amateur, are always given a very rigid examination, especially as to the heart, lungs and urine, and if cardiac disease, lung disease or albumen are found the rule is to decline. If we are wrong either in theory or practice we are ready to receive instruction. If athletes are as good as any other class of applicants we would be pleased to know why they are as good. If inordinate exercise is not to be feared as a cause of heart strain or muscular degeneration, of cardiac hypertrophy, of injury to cardiac valves and similar conditions, we would be pleased to be instructed. We may be doing companies a great injury by rendering them liable to lose good business, and that is what every medical examiner especially wishes to avoid.

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All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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NOTES.

TINCTURE of adonis estivalis is a very effective anti-fat remedy.

*

GREEN tea, or coffee, or better still, tannin, is antidotal to tartar emetic, rendering it inert.

*

SMALL doses of podophyllin are a beneficial adjunct in the treatment of old syphilitic lesions.

*

THE sulphate of aluminum is the new injection for gonorrhea—one part to 500 or 1000 of distilled water.

*

LIME-WATER and pepsin should not be prescribed together. The lime-water neutralizes the effect of the pepsin.

*

COMMON vinegar is an old application for burns and scalds. It is said to give prompt relief if continued for several hours.

*

CHROMIC acid should never be combined with glycerine, as the oxygen from the latter is readily liberated and rapid oxidation may result.

*

LACTIC acid in large amounts, with an exclusive meat diet, seems to be the accepted treatment of diabetes. Buttermilk, when a good article is obtainable, may be tried as a substitute.

READING NOTICES.

Listol.—The peculiar and individual action of Listol on a diseased surface makes our Listol (Vaginal Astringent) tablets matchless for leucorrhea, prolapsus, ulceration, chronic inflammation and all troubles incidental to the uterus.

*

Pinus Canadensis.—R. W. St. Clair, M. D., Brooklyn, N. Y., says: In two cases of diphtheria I used Pinus Canadensis, 1 ounce to one-half pint of water, with the best results. The membrane peeled off and no new formed. In leucorrhea, gonorrhea, gleet, etc., it is all that is needed. I know of nothing to take its place. I prescribe it many times daily; as a rule, I do not advocate injections into the womb, but I have in cases of endometritis used the Pinus Canadensis (Kennedy's always) with great satisfaction to myself and to my patients.

*

Antikamnia.—In speaking of the treatment of pneumonia by quinine and antikamnia, Prof Palmer says: "The effects desired, and certainly, as a rule, produced, are a decided reduction of the temperature, a marked diminution in the frequency of the pulse, a decided moisture of the skin, or free sweating, a slower and more easy respiration, or relief from pain and the feeling of fullness in the chest, a diminution of the cough and of the tenacious and bloody character of the expectoration; and, in short, not only is there a checking of the fever, but of all evidence—general and local—of the pulmonary engorgement and inflammation.

*

Trional.—Dr. L. Stieglitz says that, in treating insomnia, in most of his cases doses of 1.0 gm. sufficed to produce a quiet and refreshing sleep and repetition of the dose was but rarely required. As sleep occurs in the course of ten to thirty minutes after its administration, it was found advisable to give it on retiring or half an hour before. In the treatment of cases of simple agrypnia, Dr. Stieglitz distinguishes two groups; first patients who are unable to sleep, and second, those who after sleeping for a few hours are restless for the remainder of the night. In some cases of the second group, the best results were obtained by giving the Trional on awaking at night. The remedy was also employed in a few cases of febrile diseases and of alcoholism, epilepsy, melancholia, sciatica, and facial neuralgia with good success.

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ORIGINAL ARTICLES.

A REVIEW OF THE NEWER SYNTHETIC REMEDIES. THEIR CHEMISTRY, PHARMACY AND THERAPY.

By Oswald L. Schreiner, Ph. G.,

Baltimore.

WONDERFUL, yes, wonderful indeed, is the progress of science, and especially that of chemistry. We have but to glance around us to see what it has done to further the happiness, the health, the education, the general welfare of mankind. Its effect has been to stimulate and increase existing industries, and it has given rise to many new, though very important ones. It is chemistry which is furnishing the artist with the infinite number of shades of color, which so delight the eye of the beholders of his work; and which is also furnishing the numerous colors which the women so delight to possess on their silks and satins. Glance but upon aniline and its derivatives and you will see what chemistry has done, not only for Germany, but for the whole world. The immense aniline factories, "Farbenfabriken," of Germany are evidence of its growth and progress.

Physicians, look about you for your most reliable and effective agents for combating disease—are they not the outcome and result of chemistry? You now have the many alkaloids separated from the inert matter which contained them, and then you have derivatives of these very alkaloids themselves, which possess different and yet very valuable medical properties, for instance, apomorphine, derived from morphine, or apocodeine from codeine. And last, though not least, the many synthetical compounds, "coal-tar derivatives," as they are called, which are creating so much interest among practitioners of medicine.

The crude drug, whose strength is unknown and variable, must go, it cannot stand ground against such a formidable foe as the definite chemical compound whose strength is always the same and whose physical, chemical and medical properties never vary. The physician knows exactly how much morphine or quinine he will get when he prescribes them, and he will know just what result to expect from the dose administered, but if he prescribed opium or cinchona he would know nothing about its strength nor activity. It is true, both opium and cinchona, and only these, have been standardized in our pharmacopeia, yet how many hundred drugs are used to-day whose strength is never known.

They are at best uncertain remedies; they are continually undergoing deterioration through age, exposure and other causes; whereas a definite chemical compound does not change, its strength is to-day what it was a year, or five years ago. There are of course exceptions, some compounds decomposing most readily, such as peroxide of hydrogen, nitrite of amyl, etc.

It is the object of this paper to consider a few of these synthetical compounds, mainly those belonging to the class of antipyretics, analgesics and hypnotics. These remedies have not come to kindle the field of medicine into enthusiasm and then leave it as barren as before, as so many others have done; they have not come to stay for a while and then fade away, to be classed among the "remedies of the past;" but they have come to stay, until their mightier derivatives gradually conquer them. Their colony is well established, and their number is continually increasing, each successive one being of more value. They are increasing, indeed, but whence comes this increase; from other countries, mainly Germany, not our own. But why is this, have we no chemists here? Of the large number of important remedies, only one, acetanilid, is manufactured in this country. Yes, it is manufactured here, but the aniline used in the process is imported. Why do we not make our own aniline, why have we no large "Farbenfabriken" to employ many thousands of men, we who are so rich in the mother substance, namely, coal?

Antipyrine.— Synonyms.— Phenyl-dimethyl-pyrazolon, phenyl-iso-pyrazolon, oxydimethyl-chinizin, dimethyl-oxy-chinizin, analgen, anodynia, parodyn, sedatin, methozin, pyrazin, pyra-zolon, phenazon.

Antipyrine is a basic substance and forms with acids well-defined salts. When phenyl hydrazine, $C_6 H_5 . NH . NH_2$,—hydrazine compounds are derived from the hypothetical compound $N_2 H_4$ or ($N H_2$—$N H_2$) by substituting alcohol radicals for hydrogen—is heated with diacetic ether

$$\left.\begin{matrix} C_2 H_3 O \\ C_2 H_2 (C_2 H_5) O \end{matrix}\right\} O,$$

methyl-oxychinizin, $C_9 H_7 (CH_3)$. $N_2 O$, is formed. In this a second hydrogen atom is replaced by the methyl group, CH_3, when dimethyl-oxychinizin, $C_9 H_6 (CH_3)_2 N_2 O$, or antipyrine is produced. The above is the practical process of manufacture, but antipyrine is now generally considered as phenyl-dimethyl pyrazolon, a derivative of pyrrol, $C_4 H_5 N$.

Antipyrine is a white crystalline powder, with slight bitter taste, odorless and very soluble in water and alcohol and chloroform, much less so in ether. It fuses at 110° to 113° C. (230° to 235° F.). With a solution of ferric chloride it gives a deep red color, even in dilute solutions, and with sodium nitrite a green color, or if the solutions be concentrated green crystals will form. Antipyrine is a very unstable substance, *i. e.*, it is readily decomposed by many substances with which it is liable to be prescribed. Physicians should be acquainted with these incompatibilities so as to avoid them. It is, however, best to prescribe it alone in simple solution in an aromatic water and some syrup, or it may be given in the form of an elixir.

The following are the more frequent incompatibilities:

Those which combine with and precipitate the antipyrine from concentrated solutions are tincture of iodine, tannic acid, and preparations of astringent drugs, carbolic acid and corrosive chloride of mercury. Resorcin or beta-naphthol form with it a putty-like mass, while chloral hydrate and salicylate of soda form an oleaginous liquid. Acetanilid, or antifebrin, and antikamnia produce with antipyrine a moist mass. The mixture with cuphorin becomes liquid, but solidifies when shaken with water.

Calomel is said to form with antipyrine a toxic combination; in acid solution the calomel is reduced to a grayish powder, probably metallic mercury in a fine state of division. Bicarbonate of soda disengages the odor of acetic ether. The following produce coloration when added to the solution of antipyrine: Dilute nitric acid (pale yellow), dilute hydrocyanic acid (yellow), ammonia alum (dark yellow), ferrous sulphate (yellowish-brown), ferric sulphate or chloride (blood red), syrup of the iodide of iron (reddish brown).

On bringing spirits of nitrous ether in contact with a solution of antipyrine, a green substance, iso-nitroso-antipyrine, resembling the aniline greens, is formed and precipitates in the form of crystalline spangles. According to investigation this compound seems to possess no toxic properties; but even if

it be completely harmless it decreases the value of the medicine in just so far as the decomposition has taken place. If, for instance, antipyrine be given in combination with sweet spirits of nitre to a patient at the crisis of a severe fever, the patient may die, not through the toxic effect of this new compound, but from the want of a proper antipyretic.

From the reactions mentioned, it will be seen that antipyrine is readily decomposed by oxidizing or reducing agents of any character and until these various decomposition products have been more closely studied, physicians should be very careful to avoid poly-pharmacy when prescribing antipyrine for both therapeutic and pharmacal reasons.

The use of this once very important drug is now on the decline, as many of its less poisonous rivals are giving better satisfaction, they being more prompt and decidedly more safe. It has been used so extensively throughout the world and its medical virtues and faults so often discussed that it is needless to mention more than the most salient points in this review. Antipyrine has been employed in the treatment of almost all diseases, in which elevation of temperature and severe pain were some of the symptoms. It has been used to meet various indications of disease. First, as an antipyretic in almost all fevers. Second, as an analgesic in neuralgia, migraine, rheumatism, etc. Third, for quieting nervous irritation and nerve storms in general, in hysterical unrest. Fourth, for combating excitability of motor nerve centers, in chorea, whooping-cough, tetanus; and in combination with bromides in epilepsia, which sometimes yields to this treatment. Fifth, as a local anesthetic in a 30 to 50 per cent. solution. Sixth, as a local hemostatic in a 5 to 15 per cent. solution, or stronger; of value in arresting nasal hemorrhage.

Antipyrine is a certain antipyretic, reducing the temperature in about half an hour, usually accompanied by profuse sweat. That the sweat is not the cause of the fall of temperature is shown by the injection of atropine which prevents the perspiration but has no effect whatever upon the fall of temperature. It has been clearly demonstrated that it decreases the production of animal heat as the result of its action on the nervous system.

Valuable as the drug may be when properly administered and the patient well watched, it has often shown untoward results even in the usual doses; many such cases are on record. This uncertainty of action is its chief drawback. Blackening of the teeth has also been reported from the internal administration of antipyrine. The blackening is the more intense the more imperfect the enamel, but may be removed by cleansing the teeth with dilute acid.

Antipyrine compounds. — Valerianate of antipyrine, which crystallizes in regular cubes, soluble in water, not disagreeable to the taste, and more active than antipyrine alone.

Valerianate of antipyrine and quinine crystallizes in long, prismatic, transparent needles, soluble in water and alcohol. It has done excellent service in neuralgia.

Benzoate of antipyrine has been obtained by Cressati by adding to solution of antipyrine a boiling solution of benzoic acid, when a yellowish precipitate is at first formed, which on cooling is converted into a crystalline mass. The mass is purified by recrystallization from alcohol. The small crystals melt at a low temperature, are soluble in water, more readily in hot water, alcohol, and ether. Salicylate of antipyrine, or salipyrine, contains 57.7 per cent. of antipyrine and 42.3 per cent. of salicylic acid. It is an odorless, white, crystalline powder, with an acidulous, not unpleasant taste, sparingly soluble in water, readily in alcohol. It is manufactured by heating together salicylic acid and antipyrine, and is purified by dissolving in alcohol and crystallizing. Its use is similar to antipyrine, but must be given in larger doses. It is claimed to be very efficient in rheumatism. The combinations of antipyrine with the phenols, mentioned before as its incompatibles, resorcin, naphthol, phenol, etc., have as yet found no application in therapeutics.

INTESTINAL FISTULA AND ARTIFICIAL ANUS.

Read Before the Gynecological Society of Chicago.

By N. Senn, M. D., Ph. D., LL. D.,
Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago, etc.

A correct appreciation of the causes which give rise to the formation of intestinal fistula is prerequisite for the adoption of appropriate treatment. The term intestinal fistula will be used in this paper to signify a communication between the lumen of any part of the intestinal tract and the surface of the body or with any of the hollow abdominal or pelvic viscera. A practical distinction must be made in regard to the size and character of such abnormal communication into (1) fistula, (2) artificial anus. The difference is one of degree and not of kind. Speaking from a purely surgical standpoint, a fistula of the bowel is an opening through which gas or only a part of the liquid and solid intestinal contents escape, while an artificial anus implies a complete interruption of the fecal circulation at the abnormal outlet. The latter condition is determined either by the size of the defect in the intestinal wall or the existence of mechanical conditions which divert the intestinal contents in the direction of the abnormal outlet and away from the distal side of the bowel. The mechanical conditions which thus divert the fecal current are either a flexion or the presence of a spur or septum at a point opposite to the abnormal outlet, caused by a projection of the intact part of the intestinal wall in the direction of the fistulous opening. The surgeon aims to produce such an obstruction to the fecal circulation when he desires to procure rest for the distal part of the intestinal tract by the formation of an intentional artificial anus. The amount of intestinal contents which escapes from the intestinal canal through such an abnormal outlet depends less on the size of the opening than the existence of one or both of the above-mentioned mechanical conditions. If the intestinal tube is straight or only slightly curved, even a large opening may resemble a simple intestinal fistula, while, on the other hand, a small opening associated with a flexion or a well-developed spur appears clinically as an artificial anus and must be treated as such. The internal fistulæ communicate most frequently with another part of the intestinal tract (bimucous fistula of Dreschfeld), the bladder, vagina and uterus.

Etiology.—Intestinal fistulæ are divided into: 1. Intentional. 2. Accidental. The surgeon occasionally resorts to the formation of an intestinal fistula or artificial anus, in the treatment of inoperable mechanical obstruction, by resorting to a colostomy or enterostomy, according to the location of the mechanical obstacle which has necessitated the operation. If in such cases the intestinal opening is to serve only a temporary purpose, it is closed by operative measures in the same manner as will be advised in the discussion of the operative treatment of accidental fistula, after the distal part of the intestinal canal has been rendered permeable spontaneously or by subsequent operative interference.

Accidental fistulæ are produced, according to the immediate cause, by: 1 Gunshot and stab wounds of the abdomen. 2. Submural injury of the bowel. 3. Ulceration of the bowel. 4. Strangulation of bowel. 5. Foreign bodies in intestinal canal. 6. Malignant tumors. 7. Intestinal actinomycosis. 8. Pelvic and other abdominal abscesses. 9. Appendicitis. 10. Unintentional injury to the bowel during abdominal and pelvic operations. 11. Ligatures. 12. Sutures. 13. Drainage tubes.

Gunshot and Stab Wounds.—Those injuries usually result in fatal septic peritonitis if the intestinal wound or wounds are large enough to permit escape

of fecal material into the free peritoneal cavity, and not subjected in time to direct operative treatment. A fecal fistula, external or internal, may result if the wound is small or if only a part of the intestinal wall has been injured, in which event the injured part becomes adherent to the parietal peritoneum or an adjacent hollow organ. A resulting circumscribed abscess may later, under such circumstances, perforate the abdominal wall or discharge its contents into the adherent organ and thus establish either an external or internal fistula. According to the experience of surgeons during the War of the Rebellion, such an occurrence is more likely to follow injury of the colon than wounds of the small intestines.

Submural Injury.—Partial laceration of the intestinal wall without a penetrating wound of the abdomen occasionally results in circumscribed peritonitis, caused by the migration of pathogenic microbes from the intestinal canal through the damaged wall to the surface of the bowel, where, if present in sufficient number, they may produce an abscess which not only completes the intestinal perforation, but may result at the same time in the formation of an external or internal fistula. Such fistulæ are usually small and close spontaneously in the course of time. In suspected submural injury of the bowel without evidences of complete rupture and fecal extravasation, it is of the greatest importance to enforce efficient treatment with a special view of preventing this remote complication.

Ulceration.—Ulceration of the bowel is frequently followed by the formation of an intestinal fistula if the free peritoneal cavity is shut off by adhesions before perforation takes place and the ulcer manifests no tendency to repair. In the upper part of the intestinal canal the round, perforating ulcer of the duodenum may produce such a result. I have observed two cases of perforating typhoid ulcer in which a diffuse abscess formed which was freely incised and drained. In one case the abscess cavity contained at least a quart of fecal material which had evidently been accumulating for more than a week. The patient's general condition was such as to contraindicate search for and suturing of the perforation. In both cases life was prolonged from one to two weeks, but the patients finally succumbed to sepsis. I can readily conceive that under more favorable circumstances such patients might recover under similar treatment with an intestinal fistula which would in all probability peel spontaneously or could be closed later by operation with a good prospect of success. From my own personal observation I am satisfied that the ulcers which terminate most frequently in the formation of an intestinal fistula are of a tubercular character. I have observed a number of such instances. The clinical course in such cases is almost typical. The localized peri-intestinal process is usually preceded by symptoms which point to a chronic catarrhal or ulcerative enteritis. A painless, cold abscess appears at the point where the perforated bowel has become attached to the abdominal wall. The abscess develops insidiously and progresses very slowly. If the abscess opens spontaneously or is incised, it contains, as a rule, no fecal material. The fistula forms later, or is produced at once if the granulations lining the abscess wall are scraped away with a sharp spoon. The communicating opening between the lumen of the bowel and the abscess cavity is temporarily blocked with granulations, which, when removed or when destroyed by suppuration and degeneration, establish the fistula through which gas and fecal contents escape. In one case I found such an abscess in the umbilical region, and in another in the right linea semilunaris. In both cases a fecal fistula was established, and the patients eventually died from the effects of the primary intestinal infection. Such fistulæ hasten the fatal termination and are not amenable to successful surgical treatment. Tubercular abscesses in communication with a perforated intestinal tubercular ulcer should not be incised. The proper treatment for such cases is tapping of the abscess, followed by injection of iodoform emulsion—a form of treatment which will postpone, if not

prevent, the formation of an intestinal fistula. König is of opinion that in many cases of tubercular intestinal fistula the primary disease starts in the peritoneum, resulting in perforation of the intestine from without inward. In such cases multiple fistulæ are often established in rapid succession.

Strangulation.—The functional disturbance of the intestine following strangulated hernia, terminating in gangrene without treatment or under conservative measures, will depend upon the extent of loss of mural tissue, and will vary from a small fistula only large enough to permit the escape of gas to a perfect artificial anus. Occasionally such an accident follows the reposition by taxis of a damaged intestinal loop. The Littré, femoral, and properitoneal herniæ are most likely to be overlooked by the surgeon, and consequently most frequently give rise to this complication.

Foreign Bodies.—Perforation of the intestinal wall by a foreign body, preceded by a circumscribed plastic peritonitis, frequently results in the formation of an abscess which, when it reaches the surface or an adjacent hollow organ, is followed by an intestinal fistula. Small, slender foreign bodies, such as needles, pins, and fish bones, often perforate the intestinal wall and find their way to the surface or into neighboring organs without giving rise to an intestinal fistula. In one case I removed four fish bones from a small abscess in the median line below the umbilicus, after which the abscess healed promptly and permanently. The foreign bodies which are most frequently found in abscesses preceding intestinal fistula are sharp fragments of bone, gall stones, and enteroliths.

Malignant Tumors.—Malignant tumors may cause intestinal fistula either by producing obstruction followed by distention and ulceration on proximal side, or by directly implicating the intestinal wall. The latter mode of origin is the most common. The malignant tumor in such instances invades by contiguity the part or organ which becomes the seat of the intestinal fistula, and at the same time perforates the intestinal wall, so that the fistula is surrounded everywhere by malignant tissue. Carcinoma more frequently pursues such a course than sarcoma. Infection of the malignant tumor with pus microbes plays often an important rôle in such cases. The suppurative infection often overshadows the malignant disease so completely that the surgeon is misled in his diagnosis and institutes treatment appropriate for abscess when the operation reveals a malignant tumor as the foundation of the difficulty. Carcinoma of the cecum complicated by suppuration has been repeatedly mistaken for appendicitis. Carcinoma of the sigmoid flexure and cecum occasionally results in a pathological anastomosis between the affected part of the bowel and an adjacent loop of the small intestine. Carcinoma of the upper part of the rectum only too often invades the bladder and results in the formation of a recto-vesical fistula. Carcinoma of the stomach and transverse colon may have resulted in pathological gastro-colostomy.

Actinomycosis.—A number of cases of intestinal actinomycosis have been recorded in which the disease in its course perforated the intestinal wall and gave rise to diffuse abscesses and intestinal fistula. The ileo-cecal region is the favorite locality for such processes. In the only case of this kind that came under my own observation the disease originated evidently in the ileo-cecal region, but the abscess reached the cavity of Retzius and was opened in the median line above the pubes.

Pelvic and Abdominal Abscesses.—By far the most frequent cause of intestinal fistula are pelvic and abdominal abscesses. Such abcesses sometimes are caused by migration of pyogenic microbes through a damaged or inflamed intestinal wall, perforate later the intestine, and finally open or are incised on the surface when the fistula is completed. The fistulous tract is often long and tortuous. More frequently a pyosalpinx or acute phlegmonous abscess of the parauterine connective tissue pursues such a course. Such abscesses open most frequently into the rectum, bladder, and intestinal coils upon the floor of the

pelvis, but they may open into the cecum and sigmoid flexure. Externally they point most frequently in the groin, but they may also reach the surface through the sacro-sciatic notch and occasionally extend to the lumbar region. The external fistulous opening may be found in any of these localities. Not an infrequent cause of intestinal fistula are tubercular abscesses resulting from tubercular spondylitis and tuberculosis of the pelvic bones. In some cases the abscess is discharged first into the cecum or rectum ; less frequently into other parts of the large and small intestines, and later reaches the surface ; or the fistula forms in the course of suppurating tubercular tracts. Rectal insufflation is an exceedingly valuable diagnostic test, not only for the purpose of ascertaining whether or not the fistulous tract communicates with the intestine, but also in demonstrating the exact location of the intestinal perforation.

Appendicitis. — Appendicitis is the most frequent cause of intestinal fistula in the ileo-cecal region. The fistula is produced in one of two ways : 1. Sloughing or perforation of the appendix. 2. Rupture of an abscess of appendical origin into the cecum or adjoining intestinal loops, with the subsequent formation of an external opening. If the entire appendix is cast off as a slough with the contents of the abscess in gangrenous appendicitis, the fistulous opening involves the cecum and occupies that part of the bowel to which the appendix is attached. Clinically such a fistula resembles a cecal fistula produced by other causes. In partial gangrene of the appendix and perforation of the organ, treated upon the expectant plan by incision and drainage without removal of the appendix, if a fistula persists, the remaining lumen of the appendix communicates with the cecum on one side and the external fistulous tract on the other. The fistulous opening into the bowel under these circumstances is so small that seldom anything else but gas escapes. Such fistulæ occasionally heal spontaneously in the course of a few weeks ; but after it has become well established, closure of the fistula without operation is not to be expected. A paratyphlitic abscess rupturing into the cecum often terminates in a permanent cure, but sometimes it results in extensive destruction of the cecal wall followed by the formation of a correspondingly large fistulous opening. The location of the cecal opening will vary according to the situation of the abscess. The cases of cecal fistula which have come under my own observation involved either the anterior or posterior wall ; but it may affect any part of the cecum, and occasionally the abscess ascends in the direction of the ascending colon, which it may perforate and cause a fistula of this part of the large intestine. I have seen three cases of fistula of the cecum following appendicitis in which the opening in the abdominal wall and cecum was large enough to insert three fingers. In all of these cases the fecal current was arrested at the opening by the presence of an effective spur formed by the projection of the opposite wall toward the opening in the cecum. It is in cases of this kind, if the abscess has been opened by the surgeon, that he is credited by the patients and friends of having cut the bowel, when in reality the intestinal opening either was present at the time the operation was made or occurred later by sloughing of the inflamed cecal wall.

[CONCLUDED NEXT WEEK.]

PRIMARY CANCER OF FALLOPIAN TUBE.—Sänger (*British Medical Journal*) in a discussion on a case of this rare disease, which was ten years ago not believed to exist, observed that since the publication of undoubted cases by Martin, Kaltenbach, Doran, and himself, other records of undoubted instances of primary cancer of the tube have been brought forward by Routier, Smyly, Wynter, and Westermark. Zweifel's case, upon which the discussion was held, will shortly be published in full.

INTESTINAL OBSTRUCTION FOLLOWING OPERATIONS IN WHICH THE PERITONEAL CAVITY IS OPENED.

ABSTRACT OF THE PRESIDENT'S ADDRESS BEFORE THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS, SEPTEMBER 20, 1894.

By George H. Rohé, M. D.,
Catonsville, Md.

OBSTRUCTION of the bowels causes between 1 and 2 per cent. of the deaths following ovariotomy and other operations involving opening of the peritoneal cavity. Sir Spencer Wells lost 11 out of his first series of 1000 cases of ovariotomy from this cause (1.1 per cent.). Fritsch places his mortality from ileus post laparatomiam at 1.6 per cent. Klotz has reported 31 cases of intestinal obstruction with 5 deaths due to this complication in a series of 421 abdominal sections and 148 vaginal extirpations of the uterus.

Secondary or post-operative intestinal obstruction may be roughly divided into two classes of cases, one due to mechanical causes—adhesions, peritoneal bands, volvulus, accidental fixation by sutures, etc., and perhaps compression in exudation masses—and another due to paralysis of peristaltic movement of the intestines following sepsis or injury to the nerve supply of the muscular coat. The obstruction may be acute—*i. e.*, occur immediately after or within a few weeks subsequent to the operation—or it may develop gradually and not become complete until months or years afterward.

The majority of cases in which the cause of the obstruction was ascertained by operation *intra vitam* or by necropsy, have been found to be due to abnormal fixation of the intestines by adhesions or to compressions by peritoneal cords or bands inflammatory in origin. The statement is attributed to Olshausen that obstruction after ovariotomy is always due to adhesions between the bowel and the pedicle. A striking instance of this form is related by Sir Spencer Wells. The speaker has seen a case where the small intestine was doubled upon itself and so firmly adherent that the gut was entirely impervious. Similar cases have been reported by Skutsch and Tuttle. Adhesions of a knuckle of bowel to the abdominal incision or to other portions of the abdominal wall have frequently been found to be the cause of the obstruction, the abnormal fixation causing acute flexure of the intestinal tube. Any hindrance to the passage of the contents of the bowel at the point of flexure causes dilatation above and consequent increase of the degree of flexion. When this occurs there is at first increased peristalsis, but if the obstruction is not soon overcome the circulation is interfered with, dilatation of the bowel with paralysis of its walls follows, and the anatomical picture of the obstruction is complete.

Sir Spencer Wells illustrates another form of obstruction in which a coil of small intestine sinks into Douglas' culde-sac and becomes fixed there by adhesions. Krug has reported a case in which the descending colon was found glued fast at an angle to the posterior surface of the uterus. J. W. F. Ross has reported a case where obstruction occurred five weeks after a complete abdominal hysterectomy. Secondary operation, which would doubtless have given relief, was advised, but was rejected by the friends of the patient.

Fritsch mentions a case where a fold of the bowel was caught under a suture, and another in which the bowel was found in the incision between two sutures. He thinks the bowel was forced between the separated edges of the incision during retching and vomiting. Sir Spencer Wells "heard of a case where a coil of intestine slipped through one of the loops of wire used as sutures for the wound, and was tightly compressed when the wire was fastened."

Joseph Price quotes an interesting case from Louis, where an adherent ovarian cyst, emptied by the trocar, so dragged upon the bowel as to cause obstruction. The opinion is expressed by Price that some cases of obstruction post laparotomiam are due to leaving old bowel adhesions undisturbed at the time of operation. Fritsch seems to lean to a similar view.

Prof. B. B. Browne of Baltimore has given the particulars of a case occurring in his practice, in which death ultimately resulted from an obstruction undoubtedly present before operation. I. S. Stone has quite lately reported a similar case. Lauenstein has described in an interesting manner the varied and curious forms assumed by intestinal and omental bands and adhesions, and has indicated the only rational method of treating them.

Among the cases of constriction by peritoneal bands, one by Dr. Charles Jacobs of Brussels deserves to be mentioned. Here the constricting band consisted of the elongated adhesion between the uterus and anterior abdominal wall following ventrofixation.

Some cases have been observed in which the obstruction was due to an internal hernia through an opening in the omentum. Skene Keith reports a somewhat apocryphal case in which obstruction was produced by an epiploic appendix passing through one of the side holes of a drainage tube. After removing the tube the obstruction was relieved.

Volvulus sometimes occurs after abdominal section, but probably only after some previous adhesion or constriction of the bowel. Two cases reported by Nieberding illustrate this.

There seems no question that by far the larger proportion of cases of post-operative intestinal obstruction are due to adhesions of the intestines to each other, to the abdominal walls, or to other viscera. This being so, it becomes necessary to inquire what causes the adhesions and if these can be prevented. Sepsis, destruction or separation of the peritoneum, the use of strong chemical antiseptics in the abdominal cavity, rough handling of the visceral or parietal peritoneum by sponges, hands, or instruments, prolonged exposure of the peritoneum to the air, and the use of certain suture materials have all in turn been accused of producing adhesions. Experiments and clinical observation have, however, shown that none of these conditions is sufficient to account for all cases. It is well known that intestinal or omental adhesions to the margins of the incision are found in nearly every case in which the abdomen is opened subsequent to laparatomy, and that they occur in cases in which all the above-mentioned conditions can be excluded. On the other hand, Küstner has reported a case showing strikingly that adhesions sometimes do not occur where they might reasonably be expected. He removed a very large tumor having firm adhesions to parietal peritoneum, omentum, bladder, fundus uteri, broad ligament, and sigmoid flexure. The adhesions were separated by the fingers and by the thermocautery. The coils of intestine were adherent and matted together. These were all carefully separated. Fourteen months later a secondary laparatomy for ventral hernia showed an absence of adhesions, either of the intestines to each other, to the parietes, or to the other abdominal viscera.

The symptoms of intestinal obstruction post laparotomiam are essentially the same as those of primary obstruction. They are, however, often masked by pain, vomiting, and tympanites—so frequently present after abdominal operations without being significative of obstruction. Unless the obstruction is due to some untoward occurrence in the technique, the significant symptoms are not likely to be present for several days subsequent to the operation. If a patient does well for three or four days or longer after an abdominal section or vaginal extirpation, and is then suddenly attacked by pain followed by vomiting, tympanites, and inability to pass feces and flatus, the diagnosis of intestinal obstruction is probable. If the vomiting becomes fecal, the pulse rapid, the urine scanty, and symptoms of col-

lapse set in, the diagnosis becomes reasonably certain. Unfortunately, however, all these symptoms are not uniformly present in obstruction. When the obstruction is high up in the small intestine, fecal vomiting is usually absent and distention is likewise less marked. In these cases, also, the bowels may move several times after the pain begins, so that the diagnosis may be more or less uncertain.

Recent observations have furnished additional data upon which to base an opinion. The late Prof. von Wahl of Dorpat first called attention to the occurrence of local distention of the bowel above the point of occlusion in mechanical obstruction. This distention begins at the point of obstruction and extends upward along the course of the bowel. In mechanical obstruction, therefore, if the case can be observed from the beginning, there will be found an elastic swelling localized at a point of the abdomen and gradually enlarging, the direction of increase in size being along the course of the constricted bowel above the constriction. The distention is attributed to rapid decomposition of the arrested intestinal contents. Coincident with this local meteorism is an increased peristaltic movement of the bowel, also above the obstruction, especially insisted upon by Obalinski and Schlange. Obalinski lays great stress upon the accurate observatiou of these symptoms, especially early in the course of the trouble. In the later stages, particularly if septic peritonitis with paresis of the intestinal walls has occurred, these distinguishing signs are no longer available. In cases of obstruction due to paralysis of the intestine from the beginning (probably always a consequence of septic peritonitis) these symptoms are not present. Here there is a uniform globular distention of the abdomen without movements of the intestines, and without noticeable contours of the bowels through the abdominal walls.

An additional diagnostic sign, according to Rosenbach, Rosin, and others, is furnished by the urinary reaction. It is claimed that in complete obstruction of the ileum there is always indican in the urine. In obstruction of the colon or high up in the small intestine this reaction is usually not present. The reaction is obtained by boiling a small quantity of the urine in a test tube and adding nitric acid *guttatim*. The urine turns to a Burgundy-red color, and a similarly colored precipitate is thrown down. This has been shown by Rosin to be a mixture of the urinary coloring matters known as indigo blue, indigo red, and indigo brown. If urine yielding this reaction is shaken a violet-colored foam is produced. Rosenbach attributes great prognostic significance to this reaction. So long as it remains the case is a grave one. If, after operation for relief of the obstruction, the reaction persists, the obstruction has not been removed. In cases where the obstruction is relieved the reaction disappears within twenty-four hours. J. H. Branham has recently confirmed Rosenbach's assertion. While this sign must be regarded as a very important one, it is not absolutely pathognomonic, as a similar reaction occurs in some other morbid conditions.

The prognosis of primary intestinal obstruction is sufficiently grave. Following closely upon an operation so serious in itself as abdominal section or vaginal extirpation of the uterus, this gravity is enormously increased. The abdominal surgeon should therefore be prepared to promptly recognize and appropriately treat this unwelcome complication.

Little need be said here of the so-called "medical treatment" of intestinal obstruction. But there are certain procedures, not strictly surgical, which are frequencly indicated, and, though they are not often curative, certainly give temporary relief. Such measures are stomach washing, rectal inflation of gas or air, and injection of fluids.

Stomach washing was first recommended in intestinal obstruction by Kussmaul to relieve the distressing vomiting. Some mild antiseptic lotion containing boric acid should be used. The lavage may be repeated every four to six hours as the vomiting or disten-

tion demands. It has been found that considerable gas is removed with the fluid contents of the stomach. Some of the matters in the upper portion of the intestinal tube are likewise siphoned out, and in this way relief always follows the washing out. At the same time it must be remembered that stomach lavage is only palliative and not curative in established mechanical obstruction.

Klotz has had much success in treating acute obstruction following abdominal section by the following method. As soon as symptoms indicating obstruction appear, he washes out the stomach with from four to six quarts of warm salt solution. Should this fail to relieve the symptoms he repeats it and then passes into the stomach through the tube a large dose (one and a half to two ounces) of castor oil. In all cases so treated the active peristaltic movements set up caused passage of flatus and feces within ten hours. Evidently it is only in cases of fresh and friable adhesions that this method can be successful.

Rectal injections of water or air may at times be curative when the obstruction is due to intussusception, volvulus, or in soft adhesions of the lower portion of the intestine, but where the obstruction is due to cords or bands they can manifestly be of no avail. They should therefore not be pushed beyond a reasonable trial. Care must be taken not to use too much pressure in making rectal injections, for fear of rupturing the bowel. Attemps to force the ileo-cecal valve must be regarded always as ill-advised, in spite of the claim sometimes made that fluids can be made to pass this gateway between the large and small intestine in the reverse direction. Too much care cannot be used in passing a rectal tube high up into the colon.

The rational treatment of intestinal obstruction following abdominal section is to reopen the abdomen either in the line of the first incision or some other point, seek for the place of obstruction, relieve the same by separating adhesions, dividing constricting or restraining bands, or untwisting a volvulus. If the gut be much distended an incision to let out the gas and fluid feces may be made and the bowel afterward carefully sutured. Gangrenous intestine must be resected and the ends joined by suture or Murphy's button. At times it may be advisable to do colotomy, but the readiness with which the ends of resected intestine can be joined with Dr. Murphy's excellent device will probably render the operation of colotomy for this condition much less frequent than formerly. If the obstruction is due to a volvulus it would probably be always advisable to resect the twisted portion of the gut, as the volvulus is extremely likely to recur. Keith advises that the long mesentery, always present in volvulus, be shortened by folding it upon itself parallel to the gut, and keeping it in place by a few stitches. A case has been reported by A. H. Cordier, in which there was constriction of intestine by a peritoneal band, followed by rupture of the gut. Abdominal section was done, the stricture relieved, and an anastomosis made with Murphy's button. The patient recovered.

When practicable it is probably always better to make the incision in the middle line, as it permits more thorough and ready exploration. Branham advises that when the abdomen is opened search should first be made for the obstruction in the iliac regions, as here obstruction is most likely to occur. If not found in either of the iliac fossæ, and if it cannot be located by local distention, the entire length of the intestine must be passed through the fingers until the constriction is found. As it not infrequently happens that there is more than one point of constriction, the examination should be thorough.

The distention and congestion of the intestine above and its pale, empty, and flaccid condition below the constriction will often enable one to find the obstruction readily. Eventration of the intestines should be avoided if possible, although if the obstruction cannot be otherwise discovered this becomes necessary.

It goes without saying that the most scrupulous attention must be paid to asepsis during the operation, and that the peritoneal cavity should be thor-

oughly flushed and drained after relieving the obstruction.

The question naturally presents itself whether anything can be done to prevent the frequent recurrence of intestinal obstruction post laparotomiam. As the obstruction is so often dependent upon adhesions, attempts have been made to prevent these. Dr. Robert T. Morris proposes to accomplish this by covering denuded peritoneal surfaces with a film of aristol powder, which he claims prevents subsequent adhesions. August Martin wipes out the pelvic cavity with a sponge saturated with sterilized olive oil just before closing the incision after laparotomy.

Cases of so-called paralytic obstruction are usually due to septic peritonitis. Here operation is rarely of service, although a case reported by W. W. Keen indicates that even in these cases one need not give up all hope.

Saline Intravenous Injections.—In severe and rapid loss of blood, presence of mind and prompt action are necessary to save life. Dr. Peter Horrocks of Guy's Hospital, London, in an article before the London Obstetrical Society relates in the *American Gynecological and Obstetrical Journal* several cases of intravenous injection of saline solution in cases of severe hemorrhage. Transfusion of blood was the natural remedy, but Dr. Wooldridge believed it was not only useless but injurious. His theories were that :

1. When a person is dead from rapid hemorrhage there is still in the body sufficient blood to cary on life, if it can be circulated.

2. Theoretically half the volume of blood could do the same work if it were given double the velocity.

3. Death from hemorrhage is due to failure of the heart, and this is due to want of extension owing to the fall in the blood-pressure.

4. This blood-pressure can be raised if as much fluid be transfused as there has been blood lost.

Following out this line of thought Dr. Horrocks performed some experiments on dogs and after treating seven cases he gives his opinion in the following summary :

1. Transfusion of blood is useless and probably injurious.

2. Water with or without salt should always be used.

3. The amount injected should equal, as far as possible, the amount of blood lost.

4. Enough fluid should be injected to cause the pulse to be perceptible at the wrist.

5. The worst cases require about six pints.

6. No patient should be allowed to die from severe hemorrhage without an attempt being made to save by injection of a copious quantity of fluid.

7. In less severe forms of hemorrhage where the patient is in a low condition, though not pulseless, intravenous injection of several pints (two to five) of saline fluid should be given, to avoid secondary syncope.

8. In the more moderate cases each one must be judged on its merits, but when in doubt it is better to inject ; many of these, however, will rally by copious watery injections into the rectum, or by subcutaneous injections into the cellular tissue between the shoulders and other parts.

* * *

Chest Pains.—Chest pains usually cause great discomfort to a patient and are not sufficiently appreciated by the physician. Dr. J. K. Crook relates a series of cases in the *American Medico-Surgical Bulletin* as illustrating the diagnostic value of chest pains. In some cases these pains are reflected from an overloaded or disordered stomach, in some cases it is a neuralgia, and in exceptional cases the lungs themselves are at fault. Most persons with pains in the chest think they have some lung or heart disease. Pneumonia causes pain but the other symptoms make the diagnosis clear. Consumption is not a disease accompanied by pain and when it does occur it is from continual coughing.

CORRESPONDENCE.

A GREAT EVIL.

WAVERLY, BALTIMORE,
September 12, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—Much is done to regulate the practice of medicine in Maryland, to wipe out charlatany and to elevate a science, noble in itself, to a standard pre-eminent and incorruptible.

But to-day there is a practice indulged in parts of our city, which the law does not reach, far more pernicious to society by its influence and the demoralization resulting therefrom so extensive, outreaching the anarchistic methods of destroying a government.

It fosters prejudice against a legitimate and respectable practice; throws responsibilities upon the shoulders of the physician who is called upon to save life endangered by the criminal, who generally escapes the law, by a *promise of secrecy* and a large fee, while the physician after all efforts is sure not to get credit or money.

It is a crime against nature and a reckless defiance of human laws to interrupt the reproductive functions by introducing crude but fatal instruments into the uterine cavity—yet this forms a large proportion of criminal practice to-day and largely in our city. It is demoralizing because it tempts young women to step aside from the apparently rugged path of virtue, confident of protection from future disgrace and a relief from a burden she would otherwise be compelled to bear. It encourages men to continue immoral practices without fear of detection and assuming the responsibilities of married life. It forms the desperate resolution in the mind of the melancholy wife and mother; unhappy in the domestic circle, or perhaps wearied and broken in health from many pregnancies, she resolves to die rather than continue child-bearing. Failing in the use of poisonous doses of medicine she learns of a person who gives quick relief for $5.00 out on Broadway or in East Baltimore; further jeopardizes health and perhaps life with frenzied eagerness.

The ablest physicians are not able to gather the rolls of money as rapidly as the murderers of law, decency and life. Do you think it is known that some of our city colleges are used as cloaks to carry on this lucrative practice? Some have matriculated; attend an occasional lecture, the clinics; take a special course in gynecology to facilitate matters; acquire a knowledge of maternal structure or practice the use of instruments and create a notoriety and practice by constant reference to the "Homeopathic or other school they are attending," and aiding Professor "So-and-So in operations." Such a class are less entitled to respect than the illiterate poltroon who has nothing but brute force and a desire to make money to stimulate his ambition.

It is of no avail for the medical fraternity to open their eyes merely to stare in the face of these glaring enormities. Something active, striking at the bottom; a rooting out of the evil by stringent measures must be done. Laws, severe, stringent, with heaviest penalties attached thereto, be enacted or, if enacted, *enforced strictly*.

It would seem that a *State Secret Agency*, if established, would put a stop to these criminal practices, aided by the physicians who at times are able to win the confidence of the patient, while in dangerous condition, and thus aid in bringing about justice. To what great extent money is appropriated in maintaining secret agencies to unfold crimes and plots perhaps less heinous, while the depletion of populatiom in America will rank second only to that of France.

Looking at the matter from whatever view of reason, efforts should be made to lessen crime and criminal practices in our cities and to perpetuate purity in life. I mention nothing new in this brief letter, but it is a subject well worthy of consideration.

Please pardon an innovation, if any, and consumption of your time. I remain

Very respectfully,

C. J. WISE, M. D.

MEDICAL PROGRESS.

BOVINE TUBERCULOSIS.—At a recent meeting of the Virginia State Veterinary Medical Association, held at Norfolk, Dr. E. P. Niles, V. M., of Blacksburg, Virginia, discussing in the *Virginia Medical Monthly* the dangers of tuberculosis in animals, especially cows, spoke of its prevention. It is very likely true that infected flesh of tuberculous animals may set up the disease in one susceptible to it, or may even start the disease in one in the unhygenic condition to receive it, even if no hereditary predisposition existed. He made the following practical suggestions:

The laws necessary to control the disease in the lower animals and lessen the mortality in man may be briefly stated as follows:

1. The most important of all, the establishment of a State Board of Health, one member of which shall be a qualified veterinarian.

2. The appointment of a qualified State veterinarian, who shall be an *ex officio* member of the State Board of Health, and work under its direction.

3. A liberal appropriation placed at the disposal of these officers, in order that they may effectually carry out their work.

4. The establishment of public abattoirs, and compelling the slaughter of all animals for meat at these places.

5. Providing for veterinary inspection of all animals slaughtered for meat. Also veterinary inspection of all public dairies.

6. The provision of some means to compensate owners of all condemned animals.

7. A law empowering the State Veterinarian to order the destruction of all condemned animals.

8. The provision of county hospitals for indigent tuberculous people.

9. Compulsory disinfection of all premises that have been occupied by tuberculous people or animals.

10. Compelling the disposal of the carcasses of all tuberculous animals by cremation.

11. Prohibiting tuberculous people from attending public gatherings in closed buildings.

With these laws in force, tuberculosis can be practically stamped out. Science is arrayed for the battle; all that is lacking is the declaration of war on the parts of the States and Government.

* * *

TRANSITORY BLINDNESS IN UREMIA.—Max Rothmann (*British Medical Journal*) remarks that acute blindness is one of the most uncommon symptoms of uremia. In rare cases it may be the only symptom. It is mostly bilateral. The ophthalmoscopic examination is usually negative. Sometimes the arteries appear narrow, or albuminuric retinitis is present. If it lasts long optic atrophy may ensue. If the pupil reaction to light remains, the prognosis is good. The localization of the disease is disputed. Temporary edema of the papilla, a lesion between the corpora quadrigemina and the locality where the perception of light is effected, passing edema in the visual cortical centers are among the views advanced. The author refers to the identical sudden loss of sight after hemorrhage, in which changes have been found in the optic nerve. He then records a case in which granular kidneys were found after death, and in which the patient was seized a couple of months previously with sudden and temporary blindness affecting first the left and then the right eye. It subsequently recurred in the left eye. Death was due to phthisis. The fibres of the optic nerves were healthy, but the sheath was thickened, as well as the vessels in the nerves. Although the case is not absolutely typical, the author thinks the amaurosis of uremic origin. In the right eye the light reflex disappeared, and returned as the sight improved. Here the blindness was due to a temporary edema of the optic sheath, without permanent change in the nerve fibres. Thus the pupil reaction can be maintained, though the lesion is peripheral. The author concludes that: 1. With severe nephritis blindness may occur with or without other uremic

symptoms, and is due to edema of the optic sheath. 2. The light reaction may be preserved, lessened, or abolished, without making this compression theory impossible. 3. The prognosis of the lost reflex is not absolutely bad. 4. After the return of sight the nerve fibers may be intact, or degenerate only in the periphery.

* * *

Antiseptic Treatment of Gonorrhea.—The great endeavor in modern therapeutics is to treat diseases antiseptically. Gonorrhea is a disease which in some cases will yield to any treatment and in other cases to none. It may occur from early childhood to late in life and the first attack is usually the severest. It is a highly contagious disease and is usually self limited.

The treatment varies very widely in different hands. Dr. Edward Pendleton advocates in the *International Medical Journal* this antiseptic treatment. After preliminary directions as to the methods of injecting the fluid, he says the penis should be washed in warm water and in a warm carbolic acid solution (1 to 30), then a simple injection of water should follow. After the injection has been used for six days the following is recommended :—

℞.—Acid. borici, ʒii
Tinct. iodi, ʒii
Glycerini, ʒi
Aquæ, q. s. ad ʒiv. M.
Sig.—Inject three times daily.

If there is no discharge for ten days after the last pus is seen the patient may be considered well.

* * *

Graves's Disease and Peripheral Neuritis.—In the last number of *Brain*, says the *London Lancet*, Mr. Arthur Maude briefly considers this subject, which he first brought forward in a communication to the Medical Society last year. The symptoms on which he grounds the hypothesis that peripheral neuritis is present in Graves's disease are: 1. The frequent occurrence of "cramp," to which Dr. Hector Mackenzie first directed attention. 2. Hyperesthesia, which, he says, is nearly always present. 3. Symmetrical paresis of the legs. 4. The altered condition of the knee-jerks, which are frequently diminished. 5. Varying degrees of numbness, tingling, and pains. 6. Localized edema, which occasionally occurs in this disease. To account for the neuritis, Mr. Maude supposes that some toxic substance is produced either from the excessive disturbance of the thyroid gland or from alterations in the alimentary canal, and that this toxic substance acts upon the peripheral nerves and gives rise to the symptoms which, he thinks, at least suggest the presence of actual changes in the nerves themselves. Of course it would be idle to exhaustively discuss this hypothesis, which will no doubt at an early date be put to a crucial test by examining the nerves by modern methods; but we would venture to doubt the correctness of the view which Mr. Maude supports.

* * *

A Premonitory Sign of Pulmonary Tuberculosis.—According to an exchange, M. Destrée of Brussels stated that unequal dilatation of the pupils was frequently to be observed in tuberculosis. If the disease was unilateral, the pupil was most dilated on the affected side; if bilateral, the dilatation was variable. This inequality of pupils is not observed in other diseases of the lungs (bronchitis, emphysema, pneumonia), but may follow an ancient pleurisy. This inequality is produced by excitation of the great sympathetic in the thorax of animals. Excitation of the hilum of the lung causes pupillary dilatation of the same side. This excitation is to be observed clinically in cases of tuberculous glands. The ganglia being altered and hypertrophied before the tuberculous lesions of the lungs are notably developed, mydriasis may occur early and form a sign, a warning. The author has observed this mydriasis five years before the pulmonary affection manifested itself in one case. He calls attention to the possibility of its being of value in the early diagnosis of pulmonary phthisis.

MARYLAND

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See Publishers' Department, Page 456.

BALTIMORE, SEPTEMBER 22, 1894.

Importance of a Prognosis.

In looking over a text-book on medicine, the division of a disease into its history, pathology, clinical history, symptoms, diagnosis, prognosis and treatment, is seen to be a natural one. The physician is interested in all the heads, but the patient and his friends take the greatest interest in the prognosis. The physician who can foretell with accuracy the outcome of a disease or the result of a surgical operation is of more value in the eyes of the laity than the most skillful surgeon or the most experienced diagnostician. This ability comes not only from a study of that particular case, but from a knowledge of the disease or deformity in question; and, much more, from the past experience of the physician or surgeon in charge, together with that of others.

One difficult question to answer, and an important one, too, is when will death occur in a fatal disease. The friends and relatives will want to be summoned not too soon nor too late, but as near as possible before the time, and happy is the man who hits with accuracy the fatal day, for his skill is noised abroad and his reputation is enlarged.

Very important legal questions, too, may hinge on the prognosis; questions of making a will, or affecting those near the majority in case of disposing of property. In cases of phthisis, it is extremely difficult to say when the end will come, but in many other diseases the day of death can be foretold with tolerable accuracy. There is perhaps no greater error in the eyes of the laity than a mistake in prognosis, and physicians should always give this point most careful consideration.

* * *

Medical Schools of Baltimore.

This is a very busy time for medical schools which are preparing to open their doors to the large number of students all over the country. It is with great pride that Baltimore can point to her facilities for giving medical instruction. Of the large number of medical schools in Baltimore, most, if not all, have made additions to their teaching strength and have fortified the weak places in order to keep up with the many competitors.

Baltimore is a favorable and a favored place for the study of medicine. No foolish legislation blocks the way to the proper pursuit of practical anatomy, the generous markets make living very cheap and good, and the short cold season is not a barrier to those who cannot stand the prolonged cold weather of northern cities. Students looking for an ideal place to study will find in Baltimore a Latin Quarter where the very atmosphere stimulates one to hard work. Baltimore, too, is perhaps the only large city in this country which has unlimited facilities for the study of disease in the negro. In a few weeks there will be several thousand more students added to the population and of these many will devote themselves to medicine.

* * *

Quenching Thirst.

There is very little in the form of potable liquids that man will not put down his throat in the endeavor to quench his thirst. At times water, the great quencher, fails and then some mixtures are brought into requisition. Lemonade and tea seem to satisfy the thirst as well as any liquid, but too much tea is not taken without harm to the economy. The delusive

idea that alcoholics of any kind will remove thirst is still kept up in spite of the fact that most persons are more thirsty after this trial than before. Men who work hard at manual labor, especially in the warmer season, and those who perspire very freely must have drink often to make up for the loss of liquid in perspiration. It would be next to impossible for them to take as much water as they want, for it would unfit them for work.

In Birmingham the workers in the large factories drink oatmeal water, that is, water which contains oatmeal, and whatever the virtue of this mixture is, it so quenches thirst and refreshes exhausted nature that it is said the public houses and grog shops are suffering for want of patronage. Many steamship lines have great trouble with their firemen and stokers who are exposed to a continuous high temperature all through the trip. These men not only work with frequent intervals of rest, but they find that oatmeal water is very refreshing and they use it altogether in preference to all other drinks. If such a simple mixture will quench thirst it will be much sought after and probably be a means of lessening intemperance and other results of drinking.

* * *

THE evil to which our correspondent calls attention in this issue was dwelt on in these columns not many weeks ago. The great evils and dangers from abortions and prostitution are well recognized and are very properly discountenanced and discouraged by all right-minded physicians, but further than that, it is hard to see just what physicians can do against these wrongs.

A Great Evil.

The truly conscientious men are very strong in their condemnation of these great menaces to society and do what they can to blot them out, but there are physicians who are lukewarm on the subject or give no thought to the matter. To such our correspondent appeals, for the criminal abortionist is too hardened to listen to any entreaty. It is true that criminal abortions are not on the decrease and in almost any city women can attempt to cover their sin by appealing to these men, whom no law seems to be able to reach.

The great trouble is to get proof. The woman very naturally shrinks from appearing against such notorious men whose reputations are gone, and even if the abortionist be arrested and fined, or even imprisoned, when released he has only to change his name, appearance and location and his illicit trade will flourish as before.

Such men are well known in every community and it should be the duty of the representative medical society, together with a prosecuting attorney, to seek to obtain evidence against such and when they were once wiped out a proper enforcing of the new medical law in Maryland would keep down the number or perhaps stamp them out.

* * *

MOST persons appreciate the value of money, but there are few who take proper care of their health. Competition in trade has led men to counterfeit and adulterate foodstuffs until faith in manufactured foods is lost. Coffee, sugar, flour, tea, spices, and the most staple articles are said to undergo change and loss of virtue because dealers exercise their ingenuity to make more money by adulterating their wares.

Pure Food.

The Pure Food Expositions which will be held in the southern cities in the next few months are intended to show the people what pure food is and what adulterations are. The management of these shows maintain that what is exhibited there is pure food and the public may use it without fear of being cheated. While much must of necessity be taken on faith, still it is very likely true that the food at these exhibits comes nearer to being pure than that bought at random.

Again, such exhibitions call the attention of the public to the difference between pure and impure food and even if they have no means of distinguishing the good from the bad, still it awakens them to the fact that there are impure foods and when a demand for pure food is aroused it is very likely that the manufacturer will begin to feel that this demand must be supplied.

* * *

THE great increase in the number of scholars in the public schools of Baltimore this season brings to light the total inadequacy of many of the school buildings. Some have so few windows that on dark days artificial light is necessary; many are badly ventilated; some have no provision for a drinking water supply sufficient for the scholars and many have playgrounds too limited.

MEDICAL ITEMS.

Dr. A. H. Powell has removed to 805 Park Avenue.

The bubonic plague is said to be a thing of the past.

Asiatic cholera seems to be gradually dying out in Europe.

An International Congress of Gynecology and Obstetrics was held at Geneva this month.

The death is announced of Dr. A. B. Miles, Professor of Surgery in Tulane University, New Orleans.

During the short time the public baths of Baltimore were open, almost twenty-five thousand baths were taken there.

By the will of a wealthy citizen, Santa Cruz will have a hospital costing a million dollars, to be erected for the deaf, dumb and blind.

The Garrett Summer Hospital for Childen, at Mt. Airy, has been closed and the children have been removed to the hospital in the city.

The Tri-State Medical Society of Alabama, Georgia and Tennessee will hold its sixth annual meeting at Atlanta, Georgia, October 9, 10 and 11, 1894.

The International Congress of Hygiene and Demography, which has just closed its session at Buda-Pesth, will hold its next meeting at Madrid, Spain.

Dr. W. W. Keen of Philadelphia has been appointed by President Cleveland as a member of the Board of Visitors at the West Point Military Academy.

The *Progrès Medical* deplores the fact that the large number of medical schools in the United States lessens the value of a degree in this country.

Dr. H. D. Gedding, Passed Assistant Surgeon, M. H. S., reports the entire absence of the spirilla of Asiatic cholera in that supposed case of cholera at Cumberland.

Dr. Thomas Lothrop, Professor of Obstetrics in Niagara University, Buffalo, and one of the editors of that excellent monthly, the *Buffalo Medical and Surgical Journal*, has returned from a visit to Europe.

The merchant tailors of Gratz have requested the rector of the University there to withhold diplomas from such students as have not paid their tailors' bills. This would be a novel way of decreasing the number of graduates in this country.

There are thirty-eight medical journals published in Russia. The censor of the press, who is obliged to read them all through in the search for something against the government, has a great burden on his shoulders.

The steamers are bringing back the physicians who have been abroad for pleasure and recreation. Dr. and Mrs. J. J. Chisolm, Dr. Robert Hoffmann, Dr. Henry M. Hurd, and Dr. Henry J. Berkeley have all arrived within the last week.

Since the death of Dr. James Kitchen of Philadelphia, Dr. Hiram Corson of Montgomery County, Pennsylvania, who will be ninety years old next month, is the oldest physician in the United States who has been in continuous practice.

Dr. George H. Rohé spent this week at Toronto at the meeting of the American Association of Obstetricians and Gynecologists, when he delivered the President's address. From there he will go to Montreal, and join Dr. James F. McShane at the meeting of the American Public Health Association in that city.

St. Louis has an ambulance whose motive power is electricity from the street car lines. From the description it must run on the tracks, so there is possibly a switch to the hospital. *Puck* long since had a cartoon showing an ambulance attached to a Broadway cable car, in which operations were in progress as the cars moved. The Baltimore car lines furnish material for such an amphitheatre on wheels.

The American Academy of Medicine, which held its nineteenth annual session last month, elected the following officers for the ensuing year. President, J. McF. Gaston of Atlanta, Ga. Vice-Presidents, Rufus P. Lincoln of New York City; William T. Smith of Hanover, N. H.; Helen C. Putnam of Providence, R. I.; Victor C. Vaughan of Ann Arbor, Mich. Secretary and Treasurer, Charles McIntire of Easton, Pa. Assistant Secretary, Edgar Moore Green of Easton, Pa. Chairman of Committee of Arrangements, C. C. Bombaugh of Baltimore, Md. The next meeting of the Academy is to be held at Baltimore at the time of meeting of the American Medical Association.

BOOK REVIEWS.

INTERNATIONAL CLINICS. A Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Genito-Urinary Surgery, Gynecology, Ophthalmology, Laryngology, Otology and Dermatology. By professors and lecturers in the leading medical colleges of the United States, Great Britain and Canada. Edited by Judson Daland, M. D., Philadelphia, Instructor in Clinical Medicine and Lecturer on Physical Diagnosis in the University of Pennsylvania; Assistant Physician to the University Hospital; Physician to the Philadelphia Hospital and to the Rush Hospital for Consumption. J. Mitchell Bruce, M. D., F. R. C. P., London, England; Physician and Lecturer on Therapeutics at the Charing Cross Hospital. David W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland, Professor of Practice of Medicine in the University of Aberdeen; Physician to, and Lecturer on, Clinical Medicine in the Aberdeen Royal Infirmary; Consulting Physician to the Royal Hospital for Diseases of the Chest. London. Volume II. Fourth series. 1894. Royal 8 vo., pp. xii—358. Philadelphia: J. B. Lippincott Co.

This volume contains papers on a variety of subjects, all presented in an attractive, colloquial manner. Dr. M. Allen Storr contributes a lecture on Paranoia, in a very original way, showing the questions he puts and the answers received. Most of the articles are shorter than usual, which gives a greater variety of subjects. These clinical lectures are always attractive and instructive.

ONE HUNDRED YEARS OF BUSINESS LIFE. 1794—1894. W. H. Schieffelin & Co., New York.

This is a very interesting record of one of New York's most solid business houses. The firm has been the means of introducing into this country some of our most valuable therapeutic aids, and the history of this honorable business life is a history of old New York from its earliest Knickerbocker days to the present time. When this house was founded the seat of the National Government was at Philadelphia and George Washington had entered on his second term as President of the United States, while in France the French Revolution was at its height. Fac-similes of the private accounts of the firm are exceedingly interesting. Few business enterprises can show such an honorable record and few men at the present day are held in such high esteem as the Mess. W. H. Schieffelin & Co.

CURRENT EDITORIAL COMMENT.

LOCAL TREATMENT OF DIPHTHERIA.

North American Practitioner.

WHILE it is well to canvass carefully the claim of antitoxin in the treatment of diphtheria until it shall be found by reason of its efficacy to supersede other remedies, it will not be wise to remit our use of those *local applications* which by practical experience have been found to be beneficial.

PROFESSIONAL SECRECY.

Medical and Surgical Reporter.

THE usefulness and good repute of the physician is based upon his worthiness of trust and the secrecy with which he preserves the confidences of his patients. No matter what may be his technical skill, if the physician fails in that good faith which preserves inviolate those communications made by his patients in all confidence, he will lose his good name and usefulness in the community in which his work lies.

LAPAROTOMY IN TYPHOID FEVER.

New York Medical Journal.

IN regard to the question of surgical intervention in perforation of the intestine due to typhoid fever, it has not yet been settled. Up to the present time recovery has not been obtained except in cases that were not serious, and never when perforation occurred during the course of the fever. The number of patients operated upon and the method employed are as yet so little known that it is impossible to say anything definite on the subject.

UNDERHAND ADVERTISING.

London Lancet.

THE privacy and dignity of the profession are threatened with a new danger which cannot too soon be exposed. We refer to the interviewer. Against coarse advertising most medical men are on their guard; but when the tempter comes in such a questionable shape and with the air of high aims and interesting purposes the unwary victim is apt to find that he has supplied a reporter with a column of "copy" before he has well realized that he is to be the chief attraction in the next issue of an evening paper in the dull season, and that his photograph, his writings, his address, his hospital appointments—indeed, his general and his special fame—are to be writ large for the rush of an admiring public to have its lost noses restored or its extinguished eyes relumed.

PUBLISHERS' DEPARTMENT.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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NOTES.

THE nitrate of cobalt is a very efficacious antidote to prussic acid.

*

VAN HOORN finds thiosinamin injections very efficacious in lupus.

*

RESORBINE is a new ointment base, which bids fair to rival lanoline.

*

THE fluid extract of jambul bark is highly recommended in diabetes.

*

ONE of the most pleasant and effective tonics is Stearns' Hemoferrum.

*

PYRIDINA is a newly recommended antispasmodic to be used in cases of asthma.

*

SNOW says that opium retards the growth of cancer, in addition to relieving its pain.

*

TOLYSAL, a derivative of tolypyrin, often accomplishes good in headache of the insane when antipyrin has no effect.

*

A TWO per cent. aqueous solution of lactic acid is an excellent remedy used as a spray in laryngitis, whether syphilitic or tuberculous.

*

GLONOINE or nitro-glycerine will remove the cravings of drink, and the injection of a one per cent. solution hypodermically is said to check an epileptic fit.

READING NOTICES.

Listol.—Listol Tablets are manufactured expressly for physicians' prescriptions; they are entirely antiseptic, soothing and non-irritating.

*

Bromidia.—Received sample of Bromidia some time ago. Since receiving same we have given it a fair test with the result that we keep it constantly on hand as a reliable sedative in all cases of insomnia and delirium arising from the abuse of alcohol or other stimulants.—The Keeley Institute, Marysville, O., Jan. 20, 1892.

*

Habitual Miscarriage.—M. D. Makuna, M. R. C. S. Eng., Lic. Med. University, Bombay, 1876, Trebeebut, Rhondda Valley, South Wales, says: I have much pleasure in expressing my satisfaction with the results I have obtained by the use of Aletris Cordial. One of my patients, who had miscarried three times previously, took Aletris Cordial during the last three months of pregnancy, and was delivered of a fine healthy boy. I ordered it at her own solicitation, as she expressed so much ease and comfort after the use of the first bottle. I am now giving it to two more patients, who have miscarried several times before, and I am in hopes of good results. I consider it a valuable addition to the Pharmacopeia, on account of its antispasmodic and nerve-tonic proportions, and I should not like to go without it.

*

Opiates not to be Preferred.—Pain, while being conservative, is oftentimes unkind and must needs be modified and controlled. Remedies like morphia, which tie up the secretions, are often objectionable. Antikamnia has no such unfavorable effects. As a reliever of neuralgia dependent upon whatever cause, and rheumatism and gout, it is of great value. In the intense pains ever present in the pelvic disturbances of women, cellulitis, pyosalpinx, et al., it is to be preferred over opiates. This drug, for convenience and accuracy of dosage, is now prescribed, to a great extent, in the tablet form. Patients should be instructed to crush the tablet before taking, thus assuring celerity. The manufacturers have thrown around their product the security of specially protected packages, for both powder and tablets. And each tablet bears a monogram indicating its composition. Physicians should, therefore, insist on the presence of these conditions.

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ORIGINAL ARTICLES.

THE RATIONAL THERAPEUTICS OF TUBERCULOSIS.

By Alward White, M. D.,

El Paso, Texas.

Since the discovery by Koch in 1883 of the bacillus of tuberculosis many plans of treatment have been put forward, of all of which I think it may, without presumption, be said, that they are irrational, in one way or another. The rational indications for the treatment of a germ disease are deduced from a knowledge of its etiology and pathology, supplemented by a proper appreciation of the normal histogenic processes by which the tissues are maintained in their integrity, and a knowledge of the means provided by nature for their defence and protection against the assaults of agencies in the environment. The purpose of rational medication should be threefold; first, the elimination of the *materies morbi*; second, the promotion of the constructive metamorphosis which is implied in the restoration of the structure and function of the diseased organ; and third, the endowment of the tissues with a degree of vital resistance, not hitherto possessed, which will render them immune to future attacks.

The rationale of the tuberculin treatment as explained by the author is anything but rational; it only undertakes to fulfil one of the indications presented. Briefly stated, he proposed by the use of his remedy to cause the destruction of the infected tissues, and their elimination through natural channels. The remedy was not supposed to have any direct action upon the bacilli, neither in destroying their vitality nor in imparing their activity; the consequences were, as pointed out at the time by Virchow, that in a given case, tuberculin being administered, the diseased tissues in the lung, constituting the foci of the disease, were broken down, the wall of granulation tissue, which nature had interposed between the healthy and the diseased structures, was destroyed, and the detritus resulting therefrom, together with the bacilli, heretofore confined to a circumscribed area, find their way into the bronchi, into the lymph spaces, into the blood vessels, and we have general, where before we had only local, infection; paralleling exactly what occurs in acute miliary tuberculosis, which it is well known is always the result of a general dissemination from some old local focus of disease.

The only conditions under which success could reasonably have been expected to follow this method of treatment would have been to first render *immune* all tissues outside of the infected area; so that when the nidus of infection was destroyed the bacilli would have no place of refuge, would literally be castaways in the life current.

Equally irrational, though for different reasons, are all the plans of treatment that contemplate the use of bactericidal agents administered with a view

to their direct action on, and destruction of, the entity of the disease, the bacilli. The promulgators were evidently carried away with the idea involved in the treatment of tape-worm, that given a remedy as fatal to the life of the bacilli as male fern is to that of the tenia, and the problem was solved. They failed to take into consideration several important facts: they greatly under-estimated the vital tenacity of the bacilli; they failed to appreciate the fact that an agent sufficiently potent to destroy the parasite would also be fatal to the host, and if they had looked beyond immediate results they would have discovered the further fact, that even granting the success of their effort to destroy the bacilli without injury to the tissues, they would still fall far short in their effort to cure the individual, since existence of the disease in an individual implies his susceptibility to reinfection, and except in extremely remote and isolated places, he would be continually exposed to contagion; so generally are the germs of tuberculosis disseminated that there is scarcely a breath we draw but contains them, and those of us who escape the disease do so, not because we are not exposed, but by virtue of our possessing a degree of vital resistance that renders us immune.

It seems to me that they have all in their attempts to formulate a rational treatment overshot the mark. Like "Thompson's colt" they have swum the river to get a drink. In attempting to formulate a rational treatment it is important to enquire into, and to find out the vis medicatrix naturæ, nature's method of dealing with the disease, and this being ascertained, to direct our efforts to the facilitation of nature's purpose. Whenever in the pride of our intellectuality we undertake to accomplish our ends by means other than, or opposed to, those employed by nature, we will be almost sure to fail in the attainments of our object. We must not forget that

"Nature is made better by no mean
But nature makes that mean; over that art
Which you say adds to nature, is an art
That nature makes."

Metschnikoff's doctrine of phagocytosis opens to our vision nature's method of combatting the disease; it teaches us that the leucocytes and the fixed tissue cells, the mikrophagi and the makrophagi are the agents which she employs, that these, in addition to their other functions, constitute the great army of defence of the republic. A Landwehr, capable of speedy mobilization and concentration at any point of attack; and in the enunciation of this discovery he sounded the keynote to the successful treatment of all diseases of bacterial origin.

The indication for treatment afforded by a knowledge of these facts is plain; it is to lend every possible assistance to the army of leucocytes, to maintain it in a degree of efficiency that will enable it to contend successfully against the foe. The significance of the fact that many of us are immune to the disease, do not contract it although continually exposed, is simply that the function of phagocytosis is efficiently performed; on the other hand susceptibility to the disease, hypotrophy, as Cohn calls it, is a disease itself, one which may be either congenital or acquired, the marked feature of which is defective nutrition manifested in the formation of tissue elements of a low grade of vital resistance, and lacking that degree of potential energy which characterizes normal tissue elements; it is an expression of the fact that the processes of leuco- and phagocytosis are not efficiently performed. Here again the rational indication for treatment is plain; it is the use of remedies calculated to promote healthy leucocytogenesis; the supplying of an abundance of proteids and the use of means which will facilitate their conversion into healthy, active leucocytes, possessing all the requisites for the proper performance of their manifold functions.

In pursuance of this purpose it is next in order to enquire what so far as our knowledge goes are the remedial agents best fitted to bring about the desired result, *i. e.*, to keep the army of leucocytes fully recruited, and maintained at the highest degree of efficiency.

The experiments of Pohl and Hofméister indicate that of all the agents experimented with, with a view to determining this question, the following drugs were, in the order in which they are named, the most efficient in causing active proliferation by the lymphatic glands of the alimentary canal of healthy leucocytes, to wit: strychnia, century, fennel oil, gentian, quassia, clove oil, myrrh and turpentine. With propriety it may be asked, Have not all or some of these remedies been tried, and with what result? They have been tried and with these results:

Dr. Thomas J. Mays, in the *Medical News*, July 22, 1893, has demonstrated, at least to his satisfaction, that strychnia, which stands at the head of the list of agents that are most active in the promotion of leucocytogenesis, is the remedy *par excellence* in phthisis. Again, the claims of Dr. J. Blake White (*American Medico-Surgical Bulletin*, April 1, 1894) in advocacy of gold and manganese in combination, as a remedy in tuberculosis, is directly confirmatory of the views above enunciated, since the value of these remedies consists in their promotion of the activity of the lymphatic system, upon which the blood so largely depends for re-enforcement of healthy material. Again the modus operandi of the beneficial effects of climate, of good hygienic surroundings, of suitable food, etc., etc., is not difficult to understand when viewed from our standpoint.

It remains for us to enquire how best to fulfil the second indication, *i. e.*, the rendering of the individual immune from subsequent attacks. In searching for a clue to the solution of this question one cannot help being struck with the fact of the *tolerance*, which by habitual use the system acquires to poisonous drugs, or what is virtually the same thing, the immunity which an attack of certain diseases confers against future exposure to the exciting cause thereof. The arsenic eater, the morphine habitué, the whiskey drinker, the man who has had syphilis, small-pox or scarlet fever, are conspicuous examples, not only of "how we will breed a habit in a man;" they are as well striking exemplifications of the truth of what Byron says that one may feed on poisons till they have no power, but become a kind of nutriment. Reasoning on this line, we think that in the cultivation of and inoculation of the individual with viruses of different degrees of potency, until the *vis resistentiæ* of the system, the degree of tolerance attained, is sufficient to successfully contend against the bacilli as their most potent form constitutes the most rational indication.

To paraphrase from Pape—

> As subtle clerks by many trades are made
> The thrice inoculated leucocyte will be
> master of his trade.

We can but think that had Koch's investigations been on this line, instead of endeavoring to evolve some subtle essence from the ptomaines secreted by the bacilli, they would have been fraught with much more successful results. In conclusion, it may be asked: "Why this article? Since it contains nothing new. Very true, but there is nothing new under the sun. The task I have had in view was the placing of the facts in our possession in their proper light, in their proper sequence, and when so placed, deducing from them logical conclusions. In other words, an effort to elevate our therapeutic methods a little higher above the plane of empiricism than they now are. It has been well said that a man must remember "that while he is a descendant of the past, he is a parent of the future, that his thoughts are as children born unto him which he should not let causelessly die, that the highest truth he sees he should fearlessly utter, knowing that he is thus playing his right part in the world, that if he can effect the part he aims at, well, if not, well also, though not as well.

Cycling in Paris.—A Paris correspondent of the New York *Medical Record* writes that there are over one hundred thousand cyclists in that city, that nearly all the leading physicians ride, next come the lawyers, then the deputies, officers, and even the Institute; the family physician prescribes the exercise as the most health-giving ever devised.

INTESTINAL FISTULA AND ARTIFICIAL ANUS.

Read Before the Gynecological Society of Chicago.

By N. Senn, M. D., Ph. D., LL. D.,
Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago, etc.

[continued from page 443.]

Injury of Bowel during Abdominal and Pelvic Operations.—Under this head it is not my attention to discuss those gross lesions of the intestines occurring during abdominal and pelvic operations which the surgeon recognizes and resorts at once to the necessary treatment. I wish more particularly to refer to overlooked and incomplete wounds of the bowel as causes of intestinal fistula. Modern gynecology encourages heroic attempts in the removal of abdominal and pelvic tumors that only a few years ago would have been regarded as inoperable by the boldest surgeons. The removal of adherent tumors and pus tubes brings the operator often in very close contact with the intestines. The inflammatory processes which have produced the firm adhesions have often resulted in great damage to the adherent part of the intestine. The intestinal wall, from pressure, cicatricial contraction, and impaired nutritition, is often found not much thicker than ordinary writing paper, hence exceedingly liable to be torn during the separation of adhesions. The intestine attached to a tumor or pelvic abscess by firm and old adhesions has lost its outer or peritoneal coat over an area corresponding with the extent of the adhesions. Unless the surgeon practices the necessary precaution of making the detachment at the expense of the tumor or tube, if he does not tear an opening into the bowel he will at least seriously damage the intestinal wall. I have no doubt that in numerous instances of this kind surgeons have overlooked minute perforations in the bowel which, if they did not result in fatal septic peritonitis, became the direct source later of an intestinal fistula. It must also be remembered that a greatly damaged intestinal wall is permeable to pyogenic microbes, and consequently becomes not infrequently the sole cause of a late infection after laparotomy, and, if the patient survives, of abscess and intestinal fistula. Every experienced surgeon will recall to his memory such mishaps when he could assure himself that in other respects the operation was faultlessly performed. The examination of detached intestinal loops for perforations or other serious damage should not be postponed until completion of the operation, as it may be impossible to find them again at that time. The inspection should be made at once and all defects remedied before additional adhesions are separated. By pursuing such a course, and by detaching the adhesions at the expense of the part to be removed, we will hear less in the future of septic peritonitis, abscess, and intestinal fistula arising from this cause after laparotomy.

Ligatures.—In small wounds and limited gangrene of the bowel Astley Cooper made a small cone, the apex of which corresponded to the injury or disease, and applied a ligature of fine silk around the base. The ligature cuts its way into the lumen of the bowel during the time the resulting defect becomes sealed by plastic lymph. We can readily conceive under what circumstances such a procedure would prove safe and efficient. If the parts included in the ligature, and the ligature itself, are aseptic, the formation of a fistula is prevented by the production of new tissue around the ligature and included mass before the ligature reaches the lumen of the bowel. If, on the other hand, the asepsis is not perfect and suppuration occurs in the track of the ligature, an intestinal perforation is very likely to ensue. After separation of an

adherent intestine bleeding points are often tied with silk. Isolation of the bleeding vessel is usually out of question and more or less of bowel tissue is included in the ligature. It must not be forgotten that under such conditions the bowel has been deprived of its peritoneal investment, and consequently the facilities for encapsulation of the ligature are diminished. If to this is added an extremely attenuated bowel wall, it is not difficult to understand in what way a ligature may sometimes give rise to a late perforation, peritonitis, abscess, and intestinal fistula.

Treatment.—The treatment of an intestinal fistula must have for its aim closure of the abnormal opening with as little interference as possible with the lumen of the bowel. The statement has been made, and is borne out by clinical experience, that many intestinal fistulæ close spontaneously. This favorable termination may be expected in cases in which the opening in the bowel is small, the immediate cause of a benign and temporary character, the general health of the patient not much impaired, and the fistulous opening in the bowel so located that it can readily become attached to the parietal peritoneum or the serous investment of an adjacent organ. The spontaneous healing of an intestinal perforation is always followed by permanent parietal or visceral adhesions. In fistulæ resulting from tuberculosis, malignant disease, and actinomycosis, spontaneous healing, from the very nature of the primary cause, is out of the question, and in the majority of these cases operative treatment with a view of closing the fistula is contraindicated. The operative treatment in such cases deserves consideration only in the event that the primary cause can be completely eliminated before an attempt is made to restore the continuity of the bowel. In fistula caused by malignant disease, in which the extent of the primary cause has rendered a radical operation inapplicable, it may be advisable to secure rest for the diseased part of the intestine by establishing an artificial anus on the proximal side. In the treatment of tubercular and actinomycotic fistulæ the primary disease must receive proper attention, and, in case it is amenable to successful treatment, the fistulæ will heal spontaneously or is subjected later to appropriate surgical treatment. Before I proceed further to the discussion of the surgical treatment of intestinal fistula it is important to refer briefly to a few of the more important points of the

Pathological Anatomy of Intestinal Fistula.—For the sake of simplicity I will describe the different forms of intestinal fistula as we observe them on the surface of the body, although the same remarks will apply to the internal fistula where similar conditions are developed.

Intestinal Fistula.—Intestinal fistula as defined in the introductory remarks of this paper presents itself in one of two forms: 1. A fistulous tract leads from the surface to the opening in the intestine. 2. The mucous membrane of the intestine lines the fistulous tract and is continuous with the skin on one side and the mucous lining of the intestine on the other. In the first variety the opening in the bowel is more or less distant from the surface, and the tract is lined by granulations. In the second variety the intestinal wall reaches the surface, and the margins of the opening in the bowel form the border of the external opening, the entire fistulous tract being lined by mucous membrane. In both instances, the opening in the bowel is lateral, the intestinal tube either straight or slightly curved, presenting no mechanical impediments to the fecal current.

Artificial Anus.— The interruption, partial or complete, of the fecal current at or in the immediate vicinity of the fistula is usually due to one of three causes: 1. Intestinal obstruction below the fistula. 2. Flexion of the bowel at a point corresponding with the location of the fistula. 3. The presence of a spur opposite the opening in the bowel. If perforation of the bowel takes place in consequence of an intestinal obstruction, the cause or causes which have given rise to this accident maintain the obstruction and all of the intestinal contents escape through the fistula, which

then serves the purpose of an artificial anus. If the perforated part of the bowel becomes flexed by adhesions or otherwise, the flexion narrows the lumen of the bowel and directs the fecal current toward the abnormal outlet. Under such circumstances a considerable part of the intestinal contents necessarily escapes through the fistulous opening. If the flexion becomes more acute the intestinal wall opposite the opening forms a spur—promontorium (Scarpa), éperon (Dupuytren)—which when fully developed completely intercepts the fecal current and transforms the fistulous opening into an artificial anus.

From these remarks it necessarily follows that spontaneous healing can only be expected in cases in which the fistulous tract is not lined by mucous membrane and in which the fecal current meets with no impediment by flexion or spur formation. As the fistulous opening in the bowel is often beyond the reach of an examination to determine the actual conditions, time plays an important part to enable the surgeon to determine whether or not surgical interference is necessary. In the absence of an *indicatio vitalis* an operation should be postponed until the clinical course has demonstrated that Nature's resources are inadequate to accomplish the desired object. An early operation is demanded if the fistula involves the upper part of the small intestines and the escape of chyle endangers life from inanition. In the absence of such an indication, and in the absence of positive proof that spontaneous healing is impossible, conservative treatment should be continued until the indications for a radical operation are established. A carefully selected diet, attention to the condition of the bowels, rest, compression over the fistulous tract, and antiseptic treatment of the suppurating tract embrace the leading indications of the expectant treatment.

Surgical Treatment. — The surgical treatment must be governed by the pathological conditions which characterize each individual case. A careful inquiry concerning the etiology and pathology in each case is therefore necessary in order to enable the surgeon to select the appropriate therapeutic resources.

Cauterization.—Cauterization of the fistulous tract is useful not only in expediting spontaneous healing in cases in which such a result is to be anticipated, but also for the purpose of removing anatomical conditions incompatible with such a termination. Nitrate of silver is most efficient in stimulating the process of repair in cases in which the tract is lined by flabby, infected granulations. Benefit from this agent can only be expected if it can be applied the whole length of the canal. Its application is worse than useless if the entire tract is not accessible either on account of its length or tortuous direction. If the fistulous tract is lined by mucous membrane, is short and readily accessible in its whole length, the Paquelin cautery can be resorted to with advantage. The cauterization must be made deep enough to destroy the entire thickness of the mucous membrane. On separation of the tubular eschar the fistulous opening is enlarged, and for a time more of the intestinal contents escape through it; but in a short time the canal becomes blocked by granulations, which eventually result in its closure. Before using the cautery the length of the tract must be carefully determined, in order to protect the bowel against injury from the point of the instrument. The same instrument is of value in the treatment of larger fistulæ lined by mucous membrane not complicated by mechanical impediments to the fecal circulation. I have resorted to this procedure in a number of cases of surface fistulæ lined by mucous membrane, and have been well satisfied with the results. Cauterization may sometimes be employed advantageously in the treatment of internal intestinal fistula, as shown by the following case recently examined and treated before the class at Rush Medical College. The patient was a housewife, 25 years old, with a good family history. The present trouble dates back to childbirth five and one-half years ago. Soon after confinement she suffered from suppurative mastitis. Six months later she had an attack of what was called in-

flammation of the bowels, being confined to bed two weeks, followed by diarrhea. Later diarrhea alternated with constipation. Two and one-half years ago an abscess formed in the left ischio-rectal fossa, which broke in the gluteal region, two inches from the anus, two or three months later. Stools later contained blood but no pus. Second opening appeared six months later in left inguinal region, from which gas and fecal matter escaped from the first, later intestinal contents from the first opening. Rectal examination revealed an indurated area about four inches above the anus, in the center of which a small opening could be felt. The patient was brought to the clinic with the expectation that a laparotomy would be made for the treatment of the intestinal fistula. Injection of peroxide of hydrogen through the inguinal fistula was followed by the escape of white foam from the opening in the rectum, which could be plainly seen through a rectal speculum. The same was observed following a similar injection into the gluteal fistula, showing that both abscess cavities communicated with the same intestinal fistula. It was my intention to close first the rectal opening. The patient was placed under the influence of an anesthetic, and, while in the Trendelenburg position, the rectal opening was freely exposed by using two Sims specula. A probe was passed from the rectum into the abscess cavity, which served as a guide to the needle point of the Paquelin cautery with which the fistulous tract was thoroughly cauterized. For a few days more fecal matter escaped through the fistula, but in the course of a week the cauterized tract was found blocked by granulations which prevented even the escape of gas. The patient has continued to improve, and at present the rectal opening is almost closed, the discharge of pus from the abscesses greatly diminished, and every prospect that this simple treatment will be followed ultimately by complete closure of the fistula and healing of the abscesses.

Drainage of Abscess Cavity.—An abscess cavity interposed between the intestinal opening and the fistulous tract on the surface or in one of the pelvic organs constitutes often an insurmountable obstacle to spontaneous healing. In many such cases the abscess cavity is imperfectly drained and is being continually contaminated by fecal material. If the abscess is so located that it can be safely and more efficiently drained, such a procedure will often accomplish all that is desired. This method of procedure is particularly indicated in the treatment of pelvic abscesses complicated by intestinal fistula. It must, however, not be forgotten that under such circumstances the organs in the vicinity of the abscess are often displaced by inflammatory adhesions and exposed to injury in efforts to secure better drainage. I will cite a case in point that came under my own observation.

A lady, 35 years of age, applied to me for treatment of an intestinal fistula in the left groin. The fistula was preceded by a pelvic abscess on the same side, which was opened above Poupart's ligament. Several weeks later gas and fecal matter escaped through the opening. This condition had existed for two years. Periodical discharge of increased quantity of pus satisfied me that the original abscess cavity had not been obliterated, owing to imperfect drainage. As I could find some induration on the left side of the uterus, I decided to drain the abscess into the vagina. While the patient was under the influence of an anesthetic the external opening was enlarged sufficiently to enable me to follow the tortuous canal into the pelvis to the left side of the uterus. With the left index finger in the vagina I could feel the point of the forceps when the instrument was pushed through the tissues and the mucous membrane incised over the point. The canal was dilated and a rubber drain half an inch in diameter drawn through, thus establishing thorough drainage. The abscess cavity was thoroughly irrigated. When I visited the patient the next day I was informed that she had passed no urine since the operation. I found the bed saturated with urine. Mistrusting what had happened, I injected into the bladder warm boric acid solution, which escaped at once through

the vaginal part of the drain. It was evident that I had transfixed with the forceps the displaced bladder. The drain was removed and a Sims catheter inserted into the bladder. The drainage of the abscess cavity from the surface was continued. The wounds in the bladder healed under this simple treatment in the course of a week, and a few weeks later the fistulous opening closed permanently.

Mechanical Repression of Spur.—The spur has been recognized as a cause of the persistence of intestinal fistula for a long time, and different methods of treatment have been devised for its removal. Desault advised the insertion of a roll of charpie into the bowel with a view of increasing the size of the lumen of the bowel and of repressing the spur. Banks inserted a large rubber tube, which he fastened in the fistula, for the same purpose. As the formation of the spur takes place in consequence of the flexion of the bowel, we can readily understand why all such mechanical devices have proved of such little value.

Removal of Spur.—The first efforts to remove the spur by operative procedure were made by Schmalkalden in 1795. He removed the spur with scissors and knife. The disastrous results which must have necessarily followed this operation led Dupuytren to accomplish the same object by a bloodless method. He devised for this purpose a clamp (enterotome), which he applied to the spur, and by tightening the screws connecting the branches made it cut its way through the tissues by causing linear necrosis of that part of the septum included in its branches. The instrument effects its object in from three to eight days. It is then again applied on the side of the linear section, and the same procedure is repeated until the spur is removed. The results of this operation were quite satisfactory before laparotomy was made a safer procedure.

In 1824 Dupuytren reported 41 cases, of which number 29 were cured and only 3 died. Later Heiman collected 83 cases with a mortality of 5.83 per cent. The most recent statistics collected by Körte comprise 111 cases with 11 deaths. In many of the cases, however, the fistula remained. After the removal of the spur the margins of the fistula were usually destroyed with the actual cautery. I shall show further on that the spur develops in consequence of flexion, and that if the flexion is arrested in the operative treatment of artificial anus its removal is superfluous. The recent advances made in intestinal surgery will render Dupuytren's operation obsolete in the near future.

Closure of Fistula by Plastic Operation.—The closure of intestinal fistula by plastic operation was introduced by Dieffenbach. It was not his intention, by the operation which he devised, to close the opening in the bowel at once, but to cover it with a bridge of skin, leaving the closure to be accomplished later gradually by granulation. Between two elliptical incisions he excised the margins of the fistulous opening.

A bridge of skin is made by making on one side of the oval defect and the necessary distance from it a curved incision twice the length of the wound, and, by undermining the skin, mobilize a bridge with which to cover the opening. The oval wound was closed by interrupted sutures. The operation leaves a crescent-shaped raw surface produced by sliding the bridge, which was left open to heal by granulation. This operation, as well as plastic closure by pedunculated flaps, had their field of usefulness before abdominal operations were rendered comparatively safe by an improved technique and the general adoption of aseptic precautions, but seldom, if ever, resorted to at the present time.

Suturing of Fistula without Opening the Peritoneal Cavity.—The closure of an intestinal fistula by vivifying its margins and suturing, without detaching the bowel or opening the peritoneal cavity, has not yielded very satisfactory results. The operation is only adapted for cases in which the intestine is attached to the abdominal wall and the fistulous opening is readily accessible, and where no canalization impediments are present. I have succeeded in two cases in closing the fistula completely and perfectly by one operation.

The first case was a young man, 18 years old, who was attacked suddenly by circumscribed suppurative peritonitis in the upper part of the abdominal cavity. An abscess formed, which was opened at the left border of the left rectus muscle a little below the level of the umbilicus. A few days later nearly all of the intestinal contents escaped through the opening. The character of the chyle which escaped indicated that the intestinal perforation was near the stomach. The amount of intestinal discharge gradually diminished in quantity, the patient's general condition improved, but the fistulous opening failed to close. When he came under my observation the external opening had contracted so that it would admit only an ordinary grooved director. A long probe could be inserted its entire length. The patient was prepared carefully for the operation by laxatives and careful dieting. The fistulous tract was enlarged in an upward direction, when, upon retraction of the margins of the wound, I found an opening in the intestine large enough to admit the little finger. The intestine was adherent to the abdominal wall. I excised the whole fistulous tract, and with it the margins of the opening of the bowel, without opening the peritoneal cavity. After satisfying myself that no spur or other canalization difficulties were in the way of a normal fecal circulation, I sutured the wound by first bringing in accurate contact the mucous membrane by fine silk sutures, placing them close together. In the next row of buried sutures of catgut I included the entire thickness of the bowel wall *minus* the mucous membrane. The next row of buried sutures of the same material included the entire thickness of the abdominal muscles, and finally the skin was sutured separately, using for this purpose again fine silk. The antiseptic dressing was retained by broad strips of adhesive plaster. Stomach feeding was prohibited for three days. The entire wound healed under one dressing by primary union. The operation was performed several years ago and the patient has remained in perfect health. I have no doubt that in this case the peritonitis and abscess resulted from perforation of a duodenal ulcer. The thickness of the intestinal wall, as well as the size of the lumen of the bowel, indicated that the fistula occupied this part of the intestinal tract. In the second case, a man aged 30, the fistulous opening involved the cecum and formed after an attack of appendicitis. The opening was large enough to introduce two fingers, and nearly all of the intestinal contents escaped through this abnormal outlet. Four or five operations had been made, with the result that after each operation the size of the intestinal opening was increased. The patient was subjected to preparatory treatment for at least a week, when a similar operation was performed as in the last case, with the same satisfactory immediate and remote results. In advising a resort to this, as far as life is concerned an absolutely safe operation, I must insist in the first place upon the necessity of freely excising the fistulous tract, removing all of the scar tissue and a circular strip of the mucous membrane lining the margins of the fistulous opening in the bowel, as well as the importance of bringing in accurate apposition the different anatomical structures by several tiers of buried sutures. A conscientious observance of these precautions will frequently reward the surgeon by success in closing an intestinal fistula by extraperitoneal suturing.

[CONTINUED NEXT WEEK.]

MAGNESIUM SULPHATE HYPODERMICALLY.—Dr. F. H. Fincke has made a clinical test of the value of the hypodermic injection of magnesium sulphate as a purgative, as first suggested by Rohé and Wade, and his report in the *Medical News* shows his preference for its use by the mouth. In twenty-five cases in which the drug was given hypodermically, he had 18 per cent. of success, and 82 per cent. of failures. By the mouth in eleven cases he had 72.7 per cent. of success, and 27.3 per cent. of failures.

CLINICAL LECTURES.

VESICO-VAGINAL FISTULA; CURETTING FOR PUERPERAL INFECTION; LABIAL OCCLUSION; ANEMIA.

DELIVERED AT THE JEFFERSON HOSPITAL, NOVEMBER 21, 1893.

By E. E. Montgomery, M. D.,

Professor of Clinical Gynecology, Jefferson Medical College; Gynecologist to Jefferson and St. Joseph's Hospitals; Obstetrician to Philadelphia Hospital.

Vesico-Vaginal Fistula.—Gentlemen: The large majority of patients who will come under your observation as specialists in gynecology will be those who suffer from sequelæ of parturition. The case I bring before you to-day is a young woman who gave birth to an illegitimate child in August last. Her labor was exceedingly difficult; it was necessary to apply instruments, and she has since suffered from a fistulous opening through which the urine escapes. In addition to this opening, we find by examination that the vaginal portion of the uterus has apparently been destroyed, so that it is difficult to find the cervix, and no cervical opening can be discovered. The patient has not menstruated since her confinement, though there have been apparent efforts towards the establishment of the function. She has several times had severe pain and an elevation of temperature, running up since she has been in the hospital to 104°, accompanied by chill which had been attributed to the effort to menstruate. Examining the septum through which the urine escapes, we find a small opening which will readily admit the uterine sound. It is situated to the left of the median line about one half the length of the vagina. Through this opening the urine can be seen trickling, and the consequence is that her clothing and person are constantly soiled. Now, it is well to remember that there are a number of communications between the bladder and the genital tract, which receive names according to their situation. Thus, an opening in the lower part affecting the urethra will be known as a urethro-vaginal fistula; an opening between the bladder and vagina is called a vesico-vaginal, or we may have the urine escaping into the vagina, when the bladder is not affected, resulting from an opening into the ureter, and known as the uretero-vaginal. In some cases the urine may be found escaping from the orifice of the cervix, hence it is known as a vesico-uterine. Fistula communicating with the bladder can generally be recognized by the situation, and the amount of urine escaping; the only condition in which there is possibility of error is where there is an opening directly into the ureter and the bladder is not involved. In such cases we may differentiate by the size and situation of the opening, the introduction of a probe, and as in this case, carrying a second probe or sound into the bladder. If the ends of these two instruments can be brought in contact we recognize that we have a fistula communicating with the bladder. If they cannot be brought in contact the inference would, of course, be that we had a fistula affecting the ureter. The latter can be established further by injecting the bladder with some colored fluid, as with milk, or water colored with cochineal, and the escape of clear fluid into the vagina, when a large quantity of colored fluid is thrown into the bladder would demonstrate the absence of any communication, and establish the inference that a uretero-vaginal fistula exists. Fistulæ vary in size, as the one before us is a small one, through which the sound can be comfortably passed. They sometimes involve the entire anterior wall of the bladder. Through such a stricture, would prolapse the anterior wall of the bladder, producing a

hernia of that viscus. The patient is constantly soiled with urine, the skin becomes irritated, the urine is frequently strongly alkaline, its salts deposit upon the skin, forming crusts, which irritate it, causing it to break, and give rise to a most distressing condition. We meet with these fistulæ much less frequently than formerly, for the reason that patients are not permitted to continue in labor for such a length of time. The head of the child being impacted in the pelvis and allowed to remain thus for a number of hours causes loss of vitality and destruction of the tissues, and the delivery is followed, a few days later, by want of control of the urine. Examination discloses that a slough has taken place, through which urine is escaping. Injury may occur through the application of instruments and the rapid delivery of the head of the child, tearing possibly an incompletely dilated cervix through its anterior lip into the bladder. In such cases the lower portion of the injury may heal, leaving an opening communicating through the cervical canal, by which the urine escapes. In closing a vesico-vaginal fistula, the usual rule is to denude the mucous membrane from the vaginal side, taking care not to injure the membrane of the bladder, for the reason that it is likely to give rise to quite free bleeding and the formation of a clot in the bladder which may be subsequently difficult to dislodge. After having a beveled denudation made from the vaginal side, sutures are introduced a third of an inch from its margin, carrying them down to the edge of the mucous membrane of the bladder and not into it, and bringing them out on the opposite side in the vagina the same distance. These sutures may be silver wire, silk, catgut, or silkwormgut, preferably the latter. They should be introduced in such a way as to bring the parts thoroughly and closely in apposition. In a small fistula such as this, instead of having a beveled surface in the vagina, I should prefer making an incision straight across its opening, dissecting up flaps on either side and then introducing a suture of fine silk on either side of the small opening through the muscular layer and tying this, so as to bring the surfaces in apposition over the opening. Then bring the flaps together also by sutures. This patient suffers from a condition of more serious moment than that of the fistulous opening, which is the evident atresia of the cervical canal. She has made efforts at menstruation the last two or three months, always attended with chill and high fever, without question due to the inability of the fluid to escape. What means shall we exercise for the relief of this condition? Shall we attempt to make an opening into the uterus and thus restore the cervical canal—an opening which must necessarily be of cicatricial character, requiring constant supervision and manipulation to prevent its contraction and the re-establishment of the atresia? Or shall we take out her ovaries and tubes and bring about a cessation of menstruation, or shall ovaries and tubes both be removed? As has been said, the establishment of a cervical canal would be attended with the necessity of frequent dilatation in order to prevent its contraction and re-obliteration. Such manipulation of itself would be necessarily painful and distressing, but in addition to that there would be a constant danger of carrying infection to the uterus, through which inflammation may extend into the pelvis, producing serious conditions that may result in the crippling and death of the patient. For this reason we do not consider an attempt to establish this canal would be a justifiable procedure. Shall we remove the ovaries? By so doing we can establish an artificial menopause, placing the parts at rest and thus prevent recurrence of these abnormal symptoms, but in a woman 20 years of age there is necessarily a certain amount of secretion which will take place from the uterine membrane itself, which in this patient has no means of escape. It is quite possible the irritation thus induced by increasing the afflux of blood to the pelvis may result in the escape of blood and its retention in the uterine cavity, thus affording opportunity for the accumulation of fluid in this cavity which may become infected, or may thin the

walls to such a degree as to lead to their rupture and escape into the abdominal cavity and the production of a severe and possibly fatal peritonitis. It is well known that if the ovaries and tubes are removed there may be in some cases an extension of the ovarian stroma upon the ligament, or small masses of ovarian stroma may be distributed upon the peritoneum which will keep up the ripening of ova and the reflex phenomena associated with menstruation. In consideration of these possibilities, then, we would advise in this patient the extirpation of the uterus itself, as well as the removal of the ovaries, should be practiced. We would advise this because the operation of itself is not a particularly dangerous one. It would have to be done, of course, through the abdominal cavity. The uterine and ovarian arteries will be ligated upon either side; this can be done beneath the peritoneum, so that after the uterus is removed down to the vagina, the peritoneum can be drawn over the denuded surface and sutured, shutting off the entire surface from the peritoneal cavity. This then is the plan of procedure we will pursue in this patient, first the closure of the opening into the bladder and then the removal of the uterus, ovaries and tube.

Curetting for Puerperal Infection.—This patient came to the house a few days ago; confined four weeks since, and presents indication of puerperal infection in the form of phlebitis. She suffers severe pain in the calf of the leg, extending up to the knee, with no indication of any inflammation in the external saphenous vein. The latter vein is the usual site of thrombus and inflammation in such conditions. The swelling of the limb following is usually denominated milk leg, for the reason that such attacks often occur during puerperal convalescence and were formerly supposed to be due to the retention of lacteal fluid. In this patient the lower part of the limb is swollen, the leg exceedingly tender. Now the development of such a condition indicates the presence of some septic material, and while we cannot hope by any operative procedure to lessen the inflammation already existing in the limb, we may prevent the further introduction into the system of septic poison if we are able to sterilize the cavity in which it has originated. For that reason I place this patient under an anesthetic and proceed to the dilatation and curetting of the uterus. As a preliminary to this procedure we carefully cleansed the vagina, using for this purpose a two per cent. solution of creolin, containing two ounces of tincture of green soap to the pint, with which the vagina is thoroughly scrubbed by introducing one or two fingers wrapped with gauze so that all debris may be removed from the folds and crypts of its mucous membrane. It is then irrigated with sterilized water. The creolin and soap solution is used for this purpose for the reason that while it cleanses the vagina thoroughly, it leaves the latter relaxed and oily, and not in that dry, stiff condition which would result from a similar use of a sublimate solution. As this patient has so recently given birth to a child, the dilatation of the uterus is not difficult. The instruments must be carefully used, not permitting them to impinge against the walls of the uterus with much force, for the reason that they may be softened and friable, and easily perforated. Having dilated the uterus we use the curette, preferring the Duke curette, as it is a sharp curette with an opening through its handle through which fluid can be thrown upon the surfaces as treated, washing away the debris, and sterilizing as thoroughly as we possibly can the uterine cavity. The latter is then packed with iodoform gauze, carrying it well to the fundus, packing it firmly into the cavity where it serves a double purpose in establishing drainage through its capillary action, and by its pressure decreasing the tendency to bleeding from injured vessels. Its presence as a foreign body stimulates the contraction of the uterus, promotes the rapidity of its circulation and through its influence as a drain it carries off large quantities of serum. The result is that a large uterus is melted down, decreased in size, and the general condition of the patient im-

proved. One great advantage of gauze in such cases is that it prevents the flabby walls from falling together and obstructing the escape of blood and serum from the uterine cavity. As we are unable to absolutely assure ourselves that sterilization has been complete, there may remain sufficient amount of decomposing material to infect such fluid and cause it to be a collection from which further infection results. The gauze is permitted to remain for three or four days, when changes will result in the canal of such a character that drainage will be no longer obstructed and the subsequent progress of the patient will be greatly facilitated.

Labial Occlusion.—It is not often that we have reason to expose children in the gynecological clinic or to examine patients before the advent of puberty, but I bring before you a child two years of age in whom there seems to be an occlusion of the vaginal orifice. As we separate the limbs you notice the closure of this orifice, leaving a small opening in front at the site of the urethra. In looking at this I am inclined to believe that it is simply an adhesion of the labial surfaces as a result of irritation and inflammation, the parts possibly have been scalded by discharge or by the urine, or neglect of cleanliness until the epithelium has been abraded and these raw surfaces lying in contact have adhered. I introduce a probe in front of this, and pressing backward, find that the line of union separates, exposing the orifice of the vagina and the intact hymen above, thus demonstrating our conclusion to have been correct. We would advise the mother to keep the parts perfectly clean, to use an astringent powder and thus obviate the difficulty in the future. If the adhesion had been permitted to remain it is quite probable that the urine flowing over it would have resulted in still further abrasion and irritation and possibly more marked obliteration of the orifice.

Anemia.—This young lady is 15 years of age, a silver burnisher ; she is employed eleven hours each day, and consequently has but little opportunity to be in the sunshine. Puberty occurred at 14. At first she was regular, the periods lasting six days and were painless. Her present sickness began shortly after her first menstruation a year ago. She now complains of pain in the left lumbar region, and has not menstruated for four months. One year ago she began to lose flesh, and is, as you see, extremely pale and anemic, suffers from temporal headache, vertigo, palpitation of the heart, a murmur at the base of the heart, and the bowels constipated. This is not an infrequent history in girls who are closely confined to work at this age. At the time when her physical development should be most cultivated and she should have out-door exercise, fresh air and good food in order to secure the highest development, she is closely confined ; the consequence is that we have her suffering from a condition in which the blood is deprived of its oxygen-carrying material — the hematin—and there is a corresponding increase of the white blood corpuscles. This form of anemia is known as chlorosis; while the patients not unfrequently look in good flesh, the skin is colorless, the lips are pale, not unfrequently the skin presents a greenish-white appearance, causing it to be known as green sickness. Such patients do not menstruate for the reason that nature, for the purpose of economy, shuts off the waste. Not unfrequently, however, we find the menstrual flow supplemented by a leucorrheal discharge, often greenish in character, quite profuse, lasting three or four days in each month. The treatment consists in promoting the general nutrition and enriching the blood. There is no necessity, of course, for any local examination. Patients should be given plenty of fresh air, moderate out-door exercise, and good food. Where possible they should be sent to the sea-shore or to the country, and if going to school, or practicing music, both should be discontinued, Music particularly, from its marked impression upon the emotional system, has a depressing influence upon them. In prescribing food the digestion should

be carefully watched and the bowels regulated. The condition is generally accompanied by constipation and one of the most important considerations will be to see that they are kept regular. The administration of iron without regulation of the bowels is of no value, indeed, of great disadvantage, as the iron will not be eliminated and the patient will be only the worse off for its use. Purgatives should be given which stimulate the action of the entire canal. Aloes or aloin in combination with rhubarb, nux vomica and belladonna will prove of value. The patient should take a pill consisting of half a grain of aloin, a grain of extract of rhubarb, and a quarter of a grain each of extract of belladonna and nux vomica, each night before going to bed. A remedy which has a specific influence upon the circulation of the pelvis—apiol—seems to exert a marked effect in the treatment of such conditions. The administration of two to four grains of apiol three times in the twenty-four hours seems to promote the general nutrition of the patient. In addition to the remedies already mentioned, there is probably no one which has a better influence upon the health than cod liver oil. The foods should be those which promote to the greatest degree the general nutrition and may be known as the blood making foods, such as milk, eggs, beef and mutton.

Lateral Traction in Hip Disease.—Dr. Calvin Gates Page records in the *Boston Medical and Surgical Journal* a number of cases of hip disease, in which he applied lateral traction to solve these four problems:

Problem 1. Are there cases which are distinctly relieved by lateral traction, and by what weight?

Problem 2. Are cases more comfortable with lateral traction alone, without, in addition, longitudinal traction?

Problem 3. What are the limits of weight in lateral traction?

Problem 4. Is the limit of longitudinal traction, gradually applied and increased, the tension on the skin—provided the limb is so placed as not to pull on the stretched Y-ligament or contracted muscles, and that the limb be not adducted?

His conclusions were as follows:

1. Lateral traction properly applied in connection with longitudinal traction gives relief in some acute cases.

2. Lateral traction alone has no advantage.

3. The amount of weight in lateral traction should be in relation to the amount of longitudinal traction. A good proportion is five pounds lateral to ten longitudinal, applied twenty-five degrees beyond a right angle. The minimum useful proportion is one to ten, the maximum eight to ten.

4. The tension on the skin is the most important factor in limiting the amount of traction when the thigh is slightly flexed, abducted and everted.

* * *

Antisepsis in Minor Surgery.—The rule at the present day is antisepsis, even in the apparently most trivial operations. Dr. E. Fletcher Ingals urges in the *Journal of the American Medical Association* greater care in cauterization of the nares and advises not only antiseptic precautions, but warns against undue haste in operating and shows the accidents that may follow. From a study of his cases he concludes that:

1. It is important that antiseptic applications be regularly employed after cauterization of the nasal mucous membrane; and that the nostril be closed by cotton for several days whenever the patient is out of doors, to prevent taking cold.

2. As a rule, at least two weeks should intervene between operations upon opposite sides, and three or four weeks between those on the same side.

3. No serious results are at all likely to follow cauterizations made in this way.

4. Practically all cases of hypertrophic or intumescent rhinitis may be cured by this treatment, though occasionally portions of the turbinated bones must be removed.

MEDICAL PROGRESS.

BRUIT DE DIABLE.—Verstraeten (*British Medical Journal*) says that his researches in determining the lower margin by auscultation, have shown that (1) heart murmurs are not conducted through the liver substance, but only the sounds; (2) in certain stomach diseases accompanied by hemorrhages a systolic arterial murmur may be heard a little to the left of the middle line; and (3) a marked venous murmur (*bruit de diable*) is present in the epigastrium in some anemia. This venous murmur is best heard midway between the navel and ensiform cartilage, about ½ to 1 cm. to the right of the middle line. It is a continuous, blowing, often musical, wavy murmur, and is influenced by respiration and the heart's action. It is mostly heard in anemic women with chronic stomach disease, diarrhea, phthisis, etc. The author has never heard it in cirrhosis of the liver. It is sometimes difficult to make out. It is inconstant. The site corresponds to the vena cava, and compression of the cava causes it to disappear. A quickening of the blood stream accentuates it. It is a frequent symptom, and the author thinks its clinical value should not be underestimated.

* * *

ASEXUALIZATION AND CRIME.—The Utopian method of dealing with criminals of a certain class by emasculation and ovariotomy respectively, is made the subject of a paper by Dr. Robert Boal in the *Journal of the American Medical Association*. It would certainly reduce the number of hereditary criminals and we know that the criminal instinct is hereditary. Still it would be very difficult to have such a law passed. The author's conclusions are:

1. That the surgical unsexing of all criminals convicted of offenses that indicate constitutional depravities that are transmissible by heredity is both expedient and practicable.

2. This penalty should be applicable to both sexes.

3. That most of the offenses against society by vicious and defective classes originate in sexual disturbance whether in deprivation or excess.

4. It limits the reproduction and transmission by heredity of the defective and criminal classes of society.

5. It inflicts a penalty that is terrifying and abhorrent without destroying life.

6. It is applicable to other offences against person or property, originating from other than sexual causes.

7. While effective, the punishment is neither cruel nor vindictive.

8. It is more effectual in changing and improving the nature of the criminal than moral instruction, confinement in prison, or houses of correction.

As to when or how the penalty recommended will be carried out must be left to the future law makers. If adopted I doubt not all the details will be arranged and perfected so as to accomplish the desired end. The present century will soon close upon us, and if the same rate of progress is kept up (as I believe it will be) during the coming one, I hope a change will be made in our criminal code in line with these suggestions. The public mind is not yet prepared to accept the change recommended and it would not now be sustained, but if the question is discussed and agitated by sociologists and the medical profession, I believe that at no distant day that change will surely come.

* * *

THE HEART AND UTERINE FIBROIDS.—Hening (*British Medical Journal*) has analyzed the history of four patients who were subject to fibroids and were further troubled with palpitations, determination of blood to the head, dyspnœa, and pains in the chest. In two cases the tumor was removed and the cardiac symptoms disappeared entirely. In the other two patients those symptoms disappeared spontaneously when the fibroids ceased to grow. In one of the latter the heart was distinctly hypertrophied, whilst in the remaining three there was no evidence of organic cardiac disease.

MARYLAND

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See Publishers' Department, Page 476.

BALTIMORE, SEPTEMBER 29, 1894.

Reliable Vaccine Lymph.

In times of need good vaccine lymph is much sought after. Dr. Samuel W. Abbott points out in the *Boston Medical and Surgical Journal* some of the difficulties in the way of getting good lymph in this country. We have not that government supervision or control as exists abroad.

In this country any firm or corporation may engage in the sale and manufacture of vaccine lymph and in many instances the private producer conducts his operations in such a manner as to secure the greatest possible returns with the least possible outlay of money. Vaccine lymph may be made not only in a doubtful manner, but its methods of sale through druggists, middlemen and traveling agents causes inert and worthless matter to be put on the market. It is said that when fresh lymph is used insusceptibility is rarely found to exist.

Reforms are needed in the method of its insertion and implantation in the heifer; the age of the animal used and the time of the collection of the lymph should be considered. Cleanliness is of the utmost importance. The author also suggests that the foreign law should be followed of killing the animal before the lymph is used to be sure that no disease is present.

These measures are very strict, but if properly performed in this country we would be much better protected against small-pox. In summing up this subject the author believes that improvement may be made in the production of vaccine lymph in this country by the adoption of the following general and special measures:

1. Cultivation and production of vaccine lymph by the United States Government for the use of the Army, the Navy and the Marine Hospital service, and for all public institutions managed by the government.

Each State to produce its own lymph for the use of its public institutions and for the use of all local boards of health of cities and towns.

2. The abolition of agents and middlemen and the issuing of lymph directly from the producers to the parties who use it, every package to be stamped with the date of its collection.

3. The employment of better and more uniform methods of inoculating animals.

4. The exclusive use of animals less than one year old.

5. Limiting the time of collecting of lymph to a period of five days, or at the outside to six days, from the date of its insertion.

6. The adoption of careful rules for every establishment relative to cleanliness, the care of animals, etc.

7. If adult animals are used, a requirement that they shall be slaughtered before the lymph is issued.

* * *

Diagnosis of Diphtheria.

It was once said that in a child with suspicious inflammation of the throat with deposit and fever, a fatal ending would prove that the disease was diphtheria, whereas a recovery pointed to croup. Now, however, the bacteriological examination of the exudate in suspected cases makes with accuracy the diagnosis early in the course of the disease.

The New York City Health Department, under the guidance of Dr. Herman M. Biggs,

has by a practical division of labor so arranged it that any practicing physician in that city having a case of suspected diphtheria may send a culture tube of this exudate from the throat of the case to the bacteriological laboratory for examination. This convenient method, as devised and described by Dr. Biggs in the New York *Medical Record*, gives evidence of the extreme utility and practicability of this plan.

Any physician may call in an inspector of diphtheria who has seen many cases and get his opinion. Then there are scattered over the city a number of depots, principally in drug stores, where culture tubes and directions for making the inoculation may be obtained by physicians without charge. A printed blank is enclosed which the physician is expected to return with his culture outfit.

These cultures are studied at the Board of Health Laboratory and a report is made to the physician. The success of this plan, apparently complicated, has exceeded all expectations. In cases of positive diagnosis, isolation and proper treatment were early instituted and when this examination gave negative results there was great relief to the physician and the family. The New York City Health Board and Dr. Biggs are to be congratulated on their work.

* * *

Antiseptics in Infectious Diseases.

PHYSICIANS are spending much time in looking for some antiseptic remedy which used internally may counteract the influence of the infectious diseases and lead to a cure, and indeed act as a preventive when danger threatens. The compounds, says Oswald G. Schreiner, Ph. G., of Baltimore, in the *Virginia Medical Monthly*, which have shown themselves to possess the greatest antiseptic and germicidal powers, belong to that class known as the phenols. They have great efficacy when used externally, but internally their poisonous properties are so great that the good they may do is not compensated for by the irritating effect on the nerves.

A dose strong enough to put to rout the invading bacilli would cause the death of the body. Here the chemist can lend a helping hand and by combining these poisonous phenols with organic acids the toxic power is obliterated while the antiseptic and germicidal power remains.

These substances occur as white crystalline powders, insoluble in water, soluble in alcohol, chloroform, ether, fixed and volatile oils, glycerine, etc. They are without the least irritating action upon the most sensitive mucous membranes; they are tasteless and odorless, or nearly so; hence have no unpleasant effect upon the senses of smell and taste. They produce no nausea nor giddiness, and do not interfere with the digestive processes in the least. They all pass through the healthy stomach unchanged; but if this be abnormal—that is, when fermentative changes are going on—small quantities of the phenols are liberated which suppress the fermentation; hence their value in fermentative dyspepsia, etc. In the alkaline juices of the small intestine, these compounds are attacked by the pancreatic ferments, and decomposed into the free phenols and the organic acids. Salol splits up into phenol and salicylic acid; naphthalol into beta-naphthol and salicylic acid; benzosol into guaiacol and benzoic acid, etc. From this it will be readily seen that the medicinal properties of these compounds is that of their components.

Another class of compounds, the carbonates, have distinctive power. Thus creosote and guaiacol carbonate may both be used in practice.

We must, however, not lose sight of the fact that the micro-organisms are only the *primary* cause of these diseases, for it is now almost generally admitted that poisonous substances formed by the bacteria are the main factors in producing the symptoms of the disease. There are three ways in which these poisonous substances may be generated: first, the bacteria themselves may be poisonous; second, the bacteria may generate a poisonous chemical substance; third, the bacteria may act upon the normal complex constituents of the body, and produce poisonous compounds which produce disease and, finally, death. At present, we can say nothing positive as to the existence of the first nor the second possibility, but we know with certainty that the third one does exist. This may be shown by the action of bacteria upon substances of known composition, when poisonous products will be generated, which, when injected into healthy animals, produce in them the characteristic symptoms of the disease represented by the micro-organisms used. A further study of the chemistry of these products is what is needed at present.

MEDICAL ITEMS.

The Hospital for Women is open for the season.

Next Monday is opening day for the medical schools.

Dr. Wiltshire has removed his office to 212 West Madison Street.

An addition to the Governeur Hospital of New York is about to be built at a cost of $200,000.

The Board of Health of the Province of Quebec has established a bacteriological laboratory.

The mother-in-law of the Mikado of Japan was recently ill. She had 423 physicians in attendance, and yet she recovered.

Dr. William T. Howard, Jr., has gone to Cleveland to take the position of Associate in Pathology in the Western Reserve University.

The Medical and Chirurgical Faculty will hold its semi-annual meeting at Cumberland, Maryland, November 21 and 22. The local physicians are taking a great interest in this meeting and it is hoped that as many as possible from other parts of the State will attend.

The Tri-State Medical Association will convene in Cumberland on November 20, immediately before the Faculty meeting. That city will have many visiting physicians in those three days and great preparations are being made for their entertainment.

In Stendal, not long since, the police forcibly closed a drug store where they found the proprietor away, and the two clerks intoxicated. Before their condition was discovered they had compounded a number of prescriptions, mixing up various drugs without any regard to directions or dosage.

The Medical Society of Virginia will hold its twenty-fifth annual session at Richmond, begining October 23. The subject for general discussion is Appendicitis, considered from all its aspects. Among those on the programme are Dr. S. J. Fort of Ellicott City, who will read a paper on Psychical Epilepsy, and Drs. L. McLane Tiffany and William F. Lockwood. The meeting promises to be a particularly successful one.

The new building regulation restricting the height of buildings in Washington, D. C., went into effect September 1, and hereafter no building will be allowed to be erected whose height above the sidewalk exceeds the width of the street in its front, nor will any building be allowed on a resident street greater than ninety feet high. On business streets it is different, and buildings may be erected not exceeding 110 feet in height in any case.

The Southern Surgical and Gynecological Association will hold its seventh annual session at Charleston, November 13, 14 and 15. The meeting promises to the most successful in the history of the organization. Papers will be presented by the leading surgeons and gynecologists of the South. The medical profession is cordially invited to attend. Dr. Cornelius Kollock of Cheraw, S. C., is President, and Dr. W. E. B. Davis of Birmingham, Ala., Secretary.

The first regular meeting of the the Johns Hopkins Hospital Medical Society will be held in the Amphitheatre of the Hospital, on East Monument Street, on Monday evening, October 1, at 8 P. M., at which time, instead of the programme, a lecture will be delivered by Professor W. D. Miller, of the University of Berlin, on "Oral Pathology in Relation to Diseases of the Associated Parts and to General Diseases." This will be fully illustrated by lantern slides. The medical profession is cordially invited to be present.

When a lawyer defends a man for his life, and by some technicality or shrewdness he gains his case that lawyer is often spoken of as "that man who saved my life." When a person is stricken down, we will say with strangulated hernia, just as sure death as hanging unless relieved, he sends for his physician who understands this technicality of nature, relieves him, not from the gallows, but certain death. He does not say "that physician who saved my life," but "through the providence of God I escaped death."

The next triennial award of the Sir Astley Cooper Triennial Prize takes place early in 1895. The value thereof is £300. All competing essays should be in the hands of the physicians and surgeons at Guy's Hospital before January 1, 1895. The subject for the competition is "the anatomical distribution of the lymphatic vessels and the physical forces concerned in the movement of the lymph." This prize is open to the whole world, except certain of the attachés of the Guy's and St. Thomas' Hospitals, London.

BOOK REVIEWS.

A TREATISE ON THE PRINCIPLES AND PRACTICE OF MEDICINE; designed for the Use of Practitioners and Students of Medicine. By Austin Flint, M. D., LL. D., Late Professor of the Principles and Practice of Medicine and of Clinical Medicine in the Bellevue Hospital Medical College, New York, etc. Seventh Edition, thoroughly revised by Frederick P. Henry, A. M., M. D., Professor of the Principles and Practice of Medicine in the Woman's Medical College of Pennsylvania. Philadelphia: Lea Brothers & Co., 1894. Pp. 15–19 to 1143. Price, $5.

The great change in this edition is the omission of the section on General Pathology. In other respects the editor has left the original text of the author untouched. About one hundred pages of new matter and all the recent diseases with the latest treatment receive consideration. Flint's Practice will always be a favorite with the medical student even if better books on the same subject have appeared.

SYSTEM OF GENITO-URINARY DISEASES, SYPHILOLOGY AND DERMATOLOGY. By various authors. Edited by Prince A. Morrow, A. M., M. D., Clinical Professor of Genito-Urinary Diseases; formerly Lecturer on Dermatology in University of City of New York, etc. With Illustrations. In Three Volumes. Vol. III.—Dermatology. New York: D. Appleton & Co. 1894. Cloth. Large 8vo. Pp. xiv—976. Sold only by subscription. Cloth, $6.50 per volume; Sheep, $7.50 per volume.

The steady advances made in the department of dermatology are so great that constant study of the best works is necessary. The third volume of this elaborate "System" contains our latest knowledge of skin diseases. While the treatment in places is a little meagre, the discourses are very complete and the numerous excellent illustrations so necessary in this subject show with life-like accuracy the lesion described.

REPRINTS, ETC., RECEIVED.

Atony of the Intestine. By Julius Friedenwald, A. B., M. D. Reprint from the *Medical News*.

A Report of a case of Brain Tumor, with Autopsies. By Irwin H. Neff, M. D. From *American Journal of Insanity*.

Primary Carcinoma of the Gall-Bladder. By Delano Ames, M. D. Reprint from the *Johns Hopkins Medical Bulletin*.

CURRENT EDITORIAL COMMENT.

FORENSIC MEDICINE IN AMERICA.

Virginia Medical Monthly.

NOTWITHSTANDING our national characteristic of being to the front in most things, we are far behind our European contemporaries in the matter of medical jurisprudence, or more correctly speaking, forensic medicine, which is *applied medicine* in the highest sense of the term.

MEDICAL MISSIONARY SOCIETY.

Kansas City Medical Record.

THE International Medical Missionary Society is again at the front, and announces plans for a $25,000 building for the purpose of educating medical missionaries. We have the utmost sympathy with the medical missionary movement, but we cannot see the least use for a special college in order to educate this class of persons. The medical missionary, if he expects to do creditable work, must receive a good medical education, and there are abundant opportunities in this city and elsewhere for the purpose.

WHO OWNS THE PRESCRIPTION?

American Therapist.

IT is generally said that the failure of the pharmacist to observe the explicit instructions of the prescriber would be a breach of faith that could not be condoned, and would not be tolerated. The question as to who owns the prescription frequently comes up and has met with different interpretations at various times, but from the standpoint of the physician there can be no question. It belongs to him and no one else; and if he sees proper, he can morally and legally require the pharmacist to return it to him as soon as he has filled the order. The patient does not pay the doctor for the prescription; the financial transaction covers the advice alone, and if he so prefers, the physician may supply the medicine direct, and this appears to settle the controversy. It is rather unfortunate that such a state of affairs should exist, and it is to be hoped that in the near future the two professions may come to treat their respective members with due courtesy and respect, thus relieving the present strained relations which have existed for some time past. The present abnormal condition is undoubtedly due to the craze among the laity to get something for nothing.

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NOTES.

CASTOR oil may be disguised in extract of malt.

*

IT is generally safe to begin treatment with a purge.

*

A BLISTER over the stomach will relieve vomiting.

*

CHRONIC ulcers recover under local application of bismuth powder.

*

LEMONADE for diabetics may be made with citric acid, glycerine and water.

*

SULPHUR taken two grains three times a day is a specific in perverted nutrition of the nails.

*

GERMAIN SÉE speaks very highly of ferratin as a nutritive tonic in divided doses of from five to twenty grains a day. It does not excite or constipate and causes a strong increase of appetite.

*

THE following is an excellent prescription in infantile diarrhea:

℞.—Listerine,
Glycerine (c. p.)
Syr. Simpl.
Aquæ cinnamon, aa ℥ i

M. Sig. Teaspoonful every one, two or three hours.

READING NOTICES.

Diabetes Insipidus.—

℞.—Ext. Ergotæ fl. . . 1 oz.
Kennedy's Pinus Canadensis, (dark) . . . 1 oz.
Ext. Valerian, fl. . 1 oz.

M. Sig. Teaspoonful three times a day.

*

Listol.—Listol Tablets are the remedy *par excellence* for the treatment of diseases peculiar to women. These tablets are superseding the old methods of treatment that have proven so unsatisfactory, and are steadily winning their way into the good graces of the profession generally.

*

Bronchitis.—

℞.—Antikamnia . . ℥ ii
Liquor Ammoniæ Acet. . ℥ iss
Mist. Glycyrrh. Comp. ℥ iv
Extra. Rad. Glycyrrh fl. ad. ℥ vi

M. Sig. Two teaspoonsful every three or four hours.

*

Trional.—The ideal hypnotic in neurasthenia must possess the combined qualities of safety, efficiency, promptness of action, ease of administration and freedom from unpleasant after-effects. According to the observations of a large number of practitioners and neurologists, Trional is the remedy *par excellence* in conditions of sleeplessness.

*

Lotsil.—Lotsil is a compound of thymel-acetamide, re-crystalized and purified by an improved process, and combined with citrate of caffeine, mono-bromide of camphor, and sodium bicarb; the formula for Lotsil accompanies each package. In fevers, with or without pain, rheumatoid maladies, neuralgia, myalgia, hemacrania, difficult and painful menstruation, etc., there is no therapeutic agent superior to Lotsil.

*

Celerina.—To overcome the appetite for strong drink we must employ a remedial agent which, while acting as a stimulant and tonic on the system, will cause no disgust for it or nausea when its use is continued for some time. In Celerina we have almost a certain cure. Celerina, while causing no nausea whatever through and by itself, will, in most cases, as extensive experience has proven, imbue the person using it with an actual disgust for, and an abhorrence of, all kinds of strong drink.

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ORIGINAL ARTICLES.

GANGRENOUS APPENDICITIS; OPERATION; CURE.

By Randolph Winslow, A. M., M. D.,

Professor of Anatomy and Clinical Surgery, University of Maryland.

H. R. B., white, aged 21 years, single, a farmer by occupation, was admitted to University Hospital on July 22, 1894. The patient has always enjoyed good health, with the exception of an attack of pneumonia, about ten years ago. About two weeks ago he had diarrhea and vomiting, alternating with constipation, and about one week ago he was taken with pain in the right iliac region, soon followed by swelling and tenderness. He was sent to the hospital by Dr. Slade of Reisterstown, who had been called to the case and had recognized its serious character.

A careful examination showed that his organs were all healthy, with the exception of those lying in the right iliac fossa. In this region there was a considerable tumefaction, situated between the umbilicus and the right anterior superior iliac spine, which was the seat of a dull pain, aggravated by pressure. The abdominal wall was tense and tender in this region. There was a constant desire to urinate, and more or less difficulty in accomplishing it. His temperature was 100° and pulse 96, when admitted, but had been higher before his admission.

There was no difficulty in determining that we had to deal with an appendicitis, with an abscess shut off from the general peritoneal cavity by adhesions. During the night he became delirious, but was rational the next morning.

On July 23, under chloroform, an incision three inches long was made parallel with the fibres of the external oblique muscle and crossing a line drawn from the umbilicus to the anterior superior spine of the ilium, at the distance of one and a half inches from the anterior superior spine (McBurney's incision). This incision lead into a circumscribed cavity, formed by adherent intestines and the abdominal wall, and filled with horribly offensive pus. The appendix floated out of the wound, and was found to be entirely gangrenous, and contained a lump of fecal matter, whilst near its base there was a perforation, from which particles of feces had escaped. On attempting to place a ligature on the base of the appendix, the whole viscus pulled off.

The cavity was gently irrigated with hot water, and then with peroxide of hydrogen, until it was quite clean, when it was lightly packed with iodoform gauze. After the operation, very little occurred to report; the wound was dressed daily. Upon one occasion, a hardened mass of fecal matter was washed out during the irrigation. The wound rapidly filled up, and the patient was discharged on August 26, 1894. The temperature remained nearly nor-

mal, but the pulse became remarkbly slow, at one time being only 44 beats to the minute.

This case is of interest from several points of view, notably so on account of the early sloughing of the whole appendix. Fortunately adhesions formed of sufficient strength to limit the suppuration to a circumscribed area, and to shut off the general peritoneal cavity. The pus was most offensive. The rapid convalescence of the patient after operation was at least extremely satisfactory, as he not only had had the disease to contend with, but a removal from the country, involving a ride of sixteen miles. The importance of a prompt resort to surgical interference is also well exemplified by the case. Twenty-four hours further delay would probably have proved fatal.

A CASE OF SUPPOSED ASIATIC CHOLERA.

By E. T. Duke, M. D.,
Health Officer of Cumberland, Md.

John Peter Walther, a German immigrant, who landed at Castle Garden, New York, September 3, 1894, left that city on B. & O. R. R. for Pittsburg, Pa., the same day. He was in company with five Syrians, two German women and one child, who were passengers on Steamship Elbe, which left Bremen August 24. He was attacked by diarrhea and vomiting on vessel and was given medicine by the ship surgeon. Somewhat relieved, he landed and proceeded on his way, was taken ill again shortly before reaching Cumberland, and when the train arrived Dr. Spear, the company's surgeon, was summoned. Thinking the case a suspicious one, I was summoned as City Health Physician. Precautions were at once taken and patient isolated. Dr. Ohr, a physician of prominence, who has passed through two epidemics of Asiatic cholera and who was a victim himself in 1854, was called in consultation and pronounced the case one of genuine cholera. Dr. Spear and myself were of the same opinion, but more reluctant to express ourselves, never having seen a case. All of the symptoms were present in a marked degree.

When I first saw him he was in collapse, skin cold and clammy, no radial pulse, features shrunken, eyeballs prominent, great prostration, weak voice, tongue cold and dry, occasional pain in bowel and severe muscular cramp in limbs and extremities, absence of all secretions, occasional vomiting of clear, colored fluids. Had had ten stools within two hours previous; vomited everything given him. There was hypersecretion of fluids in stomach shown by amount of vomited fluid. Thirst was intense. Great pallor of the skin with blue lines about eyes and mouth. Hypodermatic injections of strychnia, morphia and atropia were given and fluids except brandy interdicted. From this time until his death he did not vomit, nor have any evacuation of the bowel. (I was unable to preserve dejecta for bacteriological examination, as closet was used before my arrival and none saved.) In about an hour he showed signs of reaction and by four o'clock P. M. a distinct radial pulse could be felt, the skin became warm, axillary temperature normal, features resumed more natural expression, face became red, and cramp became very severe, causing him to draw body double and cry out with pain, which he had not previously done. Pulse about 120-130. There was great restlessness during this time, patient moving arms and limbs and sitting up in bed. Muscular strength was retained in a great degree. There was total absence of all secretions at this time, notably of the urine, the sweat and salivary glands. He talked, smiled and asked for beer and food. He continued in about this condition until seven o'clock P. M., gradually grew worse and died an hour later. The case was reported to the State Health Board and to the Marine Hospital Bureau. I obtained specimens of intestine from which Dr. H. D.

Geddings of the Marine Hospital Bureau made bacteriological examination. He reported the next day that examination gave negative result. From the history and clinical evidence I am inclined to think the case one of true Asiatic cholera. The bacteriological examination was made from only one portion of intestine and report made on it in sixteen hours afterwards. In a satchel belonging to the immigrant were found two dressed fowls and a piece of cheese. These two articles are said by German authorities to be *specially* apt to carry the germs of the disease. The man was from an infected district, as well as one of the women, and his baggage was marked disinfected. There were five Syrians in the party, which is also confirmatory of the belief already expressed that the man died of cholera. Quarantine officers thought it impossible that he could pass quarantine having the disease or develop it after so long a time. I think it not impossible at all. I quote from the U. S. Government Report on "Cholera in Europe and India," page 830: "It must be further admitted that it is quite possible that notwithstanding the fact of having undergone quarantine, some persons coming from a locality attacked by cholera may introduce the infective material into the State which he desires to enter. It can be carried in their effects and in their persons by means of that simple and innocuous affection—really the beginning of cholera—designated as choleraic diarrhea." Again from the same authority: "It is true that sometimes the period of incubation seems to have a greater period (than three days) of duration, even of some weeks, but these are exceptional cases in which it may be doubted if this prolongation of the incubation may not be more apparent than real, because the infection might have occurred later than it seemed through infective material existing in the effects of the attacked; the latter after having departed from infected centers in a perfect state of health, may become infected beyond the centers themselves, and in a locality perfectly healthy, by these effects if they contain the morbific germs."

Post-mortem appearances were those of Asiatic cholera. The tissues were extremely dry. There was seen a cyanotic hue of the skin in dependent portions of the body. Muscles firm, dry and dark-red in color. Bladder, stomach and intestines empty. Rigor mortis came on soon after death.

In cholera morbus there is usually an increased secretion of bile shown by vomited matter being colored. In this case the vomited matter was colorless. Usually patients recover after reaction from collapse in cholera morbus.

There were in the case of this immigrant some symptoms appreciable to the minds of the medical attendants, yet indescribable, so unlike any case of cholera morbus, of which we had seen so many.

It is true the bacteriological examination in the case was negative. This has not sufficient weight when we remember only one specimen was examined, and that thirty-six hours after death, an opinion being given in sixteen hours. Bacteriological examination made in an epidemic in Germany several years ago demonstrated the fact that out of thirty cases of supposed cholera only eight gave positive evidence of the comma bacillus (U. S. Government Reports).

I close with the remark that whether or not the disease was Asiatic cholera every possible precaution was taken to prevent any spread of infected material.

Note.—A bacteriological examination failed to show the characteristic spirilla.

THE EFFECTS OF CHLOROFORM ON THE KIDNEYS.—Alessandri (*British Medical Journal*) draws attention to the fact that in most cases the effects of chloroform on the kidneys are practically *nil*. In patients with renal affections, however, this condition of perfect safety cannot be said to exist, and the author urges very strongly the necessity of carefully observing the urinary secretion for one or two days after the administration of chloroform. When renal lesions are actually in existence chloroform should either be avoided, or at least given with the greatest caution, and prolonged or repeated anesthesias are inadmissible.

INTESTINAL FISTULA AND ARTIFICIAL ANUS.

READ BEFORE THE GYNECOLOGICAL SOCIETY OF CHICAGO.

By N. Senn, M. D., Ph. D., LL. D.,
Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago, etc.

[CONTINUED FROM PAGE 465.]

Intestinal Anastomosis.—The formation of an intestinal anastomosis in the treatment of an intestinal fistula is indicated in cases in which the extraperitoneal methods are not applicable or have proved unavailing and the usual intraperitoneal operations are contraindicated. Under such circumstances the exclusion from the fecal circulation of the perforated loop by the formation of an anastomotic communication between the afferent and efferent limbs of the loop, will remove the annoyances incident to an intestinal fistula and place the parts in a more favorable condition for spontaneous healing or more successful surgical intervention. The anastomotic opening should be made at least two inches in length. The operation can be performed most safely by the use of decalcified perforated bone plates or by Czerny-Lembert sutures. For the purpose of showing the value of this methop of procedure in rare cases I will relate a case that came under my observation a few years ago. A lady, 30 years of age, suffered for several weeks from pelvic peritonitis, which resulted in the formation of an abscess, which was opened above Poupart's ligament on the left side. A few days after the abscess was incised gas and fecal matter escaped from this opening. Additional abscesses on the same side appeared, which were either opened externally or discharged through the first abscess cavity. The fecal fistula remained. The case came under my charge in my hospital service nearly a year after the first attack. The patient was greatly emaciated ; more than one-half of the intestinal contents escaped through the abnormal outlet. The fistulous tract led down into the cavity of the pelvis to the left of the uterus. Rectal insufflation of hydrogen gas demonstrated that the fistula was above the ileo-cecal valve. After a few days of preparatory treatment I opened the abdomen and found the lower part of the ileum rolled up into a mass by numerous and firm adhesions. I made a faithful attempt to unravel the mass, but had to abandon the task. I could not find the perforated part of the intestine. The mass comprised from three to five feet of the lower part of the ileum. Excision of this mass was absolutely out of the question, owing to the patient's general condition and the number and character of the adhesions. I finally succeeded in finding the intestine on the proximal side and established between it and the adjacent sigmoid flexure a communication with the aid of large decalcified perforated bone plates, and closed the external incision. Very little fecal material escaped from the fistula after the operation, while the discharges from the bowel become more copious and liquid. It was evident that the fecal current had been diverted away from the numerous adherent coils of the lower part of the ileum into the sigmoid flexure. The patient improved in general health and was relieved from the annoyances incident to an intestinal fistula. A number of times the fistulous opening closed, but reopened ; this occurrence is always attended by a limited discharge of pus. The abscess cavity has evidently never healed completely and undoubtedly maintains the fistula. I anticipate that the excluded part of the intestinal canal will continue to undergo progressive atrophy, and that ultimately the fistulous opening will close spontaneously. So far the operation has resulted in restoring the continuity of the intestinal canal by excluding from functional

activity the partially impermeable lower part of the ileum. It appears to me that a similar procedure would often prove of great value in the treatment of vesico-intestinal fistula in which the operative closure of the opening and enterectomy are impracticable.

Enterectomy.—The mortality attending enterectomy and circular enterorrhaphy in the treatment of intestinal fistula and artificial anus remains great even in the hands of experienced operators. The statistics of Reichel give a mortality of 37.8 per cent., and those of Hertzberg 27 per cent. In view of this fact it is apparent that this operation should be reserved for cases not amenable to successful treatment by safer procedures. I am confident that the indications for this operation can be limited to *exceptional* cases. If the intestine is not attached to the abdominal wall, it is much safer to open the free peritoneal cavity in search for the affected part of the intestine than to follow the fistulous tract as a guide. If possible, the intestine should be tied on each side of the fistula with a strip of gauze or a rubber band before it is detached, in order to guard more efficiently against fecal extravasation. The operation should be performed with the patient in the Trendelenburg position and the peritoneal cavity amply protected by aseptic compresses during the resection and suturing. After the resection the continuity of the bowel should be restored by circular enterorrhaphy by Czerny-Lembert sutures.

Sutures.—Careless suturing of the abdominal incision is responsible for many accidents to the intestines. Undue haste in completing this part of the operation is often severely punished. Unless the operator resorts to proper precautions the needle may transfix a part of the circumference of the small intestine; on tying the suture the loop is anchored against the external incision, the ligature later cuts its way through the included part of the bowel, and if a fatal peritonitis does not result an intestinal fistula is sure to follow. I have seen two cases of intestinal fistula, in the practice of distinguished surgeons, where I had reason to believe that the intestinal fistula had such an origin. But this is not the only way in which sutures have produced this complication. In tying the sutures a loop of the underlying intestines may be caught between the suture and the abdominal wall, and on tightening the suture strangulation results, followed by intestinal obstruction, gangrene of the strangulated part of the bowel or coil, abscess, and fistula. Again, an intestinal coil may escape between the sutures and become strangulated between the margins of the wound with similar consequences. It is time that surgeons should recognize the suture as a cause of such complications and resort to efficient prophylactic measures. I am strongly convinced of the value of a separate row of buried absorbable peritoneal sutures in closing the abdominal incision, both for the purpose of guarding against accidents to the intestines and as a prophylactic measure against ventral hernia. Whenever it is possible the omentum should be drawn downward far enough to cover the entire length of the incision. The use of the aseptic compress as an aid in suturing the external wound is so well known that it is only necessary to mention it in connection with any subject.

Drainage Tubes.—The last, but by no means the least, important subject which I shall discuss in connection with the etiology of intestinal fistula is the drainage tube. Prolonged tubular drainage with glass or rubber tubes is a well-known factor in the production of intestinal fistula. The opening in the bowel is produced by pressure atrophy. I am inclined to believe that the elastic pressure caused by rubber drains is more injurious than that exerted by glass tubes. Long-continued tubular drainage for suppurative lesions is more dangerous in this respect than similar methods of drainage for parenchymatous oozing or other aseptic pathological conditions. In the former case the suppurative inflammation along the drainage canal adds to the destructive effect of pressure. It will be difficult, if not impossible, to entirely eliminate this etiological element by any amount of care

in cases requiring long-continued tubular drainage. In recent cases necessitating drainage for a few days I have been in the habit of surrounding the glass or rubber drain by a few layers of iodoform gauze, for the purpose of diminishing the harmful effects of localized pressure. In drainage for suppurative affections it is advisable to gradually reduce the size of the tube for the same reason, and whenever practicable interpose betwen the intestine and tube a few layers of iodoform gauze.

Preliminary Transverse Suturing of the Intestinal Opening as a Prophylactic Measure against Infection during the Operation for Artificial Anus.—There can be but little doubt that the operative treatment of intestinal fistula or artificial anus requiring opening of the abdominal cavity has been attended by an alarming mortality, owing to infection caused by the escape of feces through the intestinal opening. Packing the opening with gauze or cotton is a very inefficient way in which to prevent fecal extravasation. The use of clamps and ligatures on each side of the opening in the bowel is equally unreliable. It appears to me the only safeguard against this course of danger is preliminary closure of the intestinal opening by suturing, placing the sutures so close together as to absolutely prevent the escape of any of the intestinal contents. After this has been done the field of operation is once more thoroughly sterilized before the abdomen is opened and the intestine detached. The sutures should include all of the tunics of the bowel. With few exceptions this row of sutures will remain as Czerny sutures, to be buried after the bowel has been detached by Lembert stitches. I have already made the statement that I look upon flexion of the bowel as the most important factor in producing the spur, and that measures which are calculated to correct the flexion will prove useful in removing the spur. In artificial anus, produced accidentally or intentionally, the flexion is caused by the prolapse of the intestinal loop into, and sometimes even beyond, the opening in the abdominal wall. If the intestine is detached the flexion is diminished or completely corrected, and its recurrence is prevented by transverse suturing of the intestinal opening. I am fully convinced of the correctness of these statements, and will corroborate them by the report of two cases of artificial anus which I operated upon in the clinic of Rush Medical College during the last session. The first patient was a man 29 years old, Irish-American. About a year before he entered the Presbyterian Hospital he was taken suddenly with severe pain in the right iliac fossa. The attending physician made a diagnosis of appendicitis, and four days later opened an abscess at a point about two inches toward the inner side of the anterior superior spinous process of the ileum. A few days later feces escaped through the opening. An attempt was made to prevent the escape of fecal matter by applying a compress. Then followed twelve operations, with the intention of closing the fistula in one of the hospitals in St. Louis. The only result effected by the operations was increased size of the opening. When the case was presented in the clinic the opening in the abdominal wall and the anterior wall of the cecum was large enough to insert three fingers. In the centre of the opening I found a well-developed spur which effectually prevented the entrance of any of the intestinal contents into the colon. The border of the opening in the abdominal wall was lined by the ectopic mucous membrane of the cecum. The ileo-cecal valve could be seen and felt below the spur. The patient was prepared for the operation by dieting, laxatives, and daily warm bath for a week. The operation was commenced by suturing the oblong vertical intestinal opening transversely, using for this purpose fine silk and an ordinary sewing needle. After the lumen of the intestine with its contents was shut off from the field of operation, the surface was once more thoroughly disinfected. The next step in the operation consisted in including in two elliptical incisions the margins of the abdominal opening and the scar tissue in its vicinity. The peritoneal cavity was opened by a straight incision extending downward from the

lower angle of the two incisions. The bowel was detached from the abdominal wall and drawn forward into the external incision. The strip of skin and scar tissue was carefully trimmed away from the bowel with scissors, when the provisional sutures were buried by a row of Lembert stitches.

The prolapsed part of the bowel was cleansed, dried, and replaced into the abdominal cavity and the external wound closed by four tiers of sutures. The usual antiseptic dressing was applied and confined in place by broad strips of adhesive plaster. Not a single untoward symptom followed the operation. The wound healed throughout by primary intention. The bowels responded to a laxative on the third day and subsequently moved daily without further assistance. The patient left the hospital at the end of four weeks with instructions to wear a pad for at least six months.

The second case was a girl 9 years old. During October last she suffered from an acute attack of appendicitis, which resulted in the formation of a large abscess. The abdomen was opened, the perforated appendix was removed. It was noticed that the anterior wall of the cecum presented a large gangrenous patch. It was deemed advisable to anticipate perforation by excluding this area from the free peritoneal cavity by a ring of sutures uniting the visceral with the parietal peritoneum. The balance of the incision was closed with the exception of a space for drainage. The patient's general condition improved promptly after the operation. The gangrenous part sloughed away, leaving a large opening in the cecum. Through this opening nearly all of the intestinal contents escaped, as an efficient spur formed at the middle of the opening. The contact of feces with the skin produced in this case an intense and diffuse dermatitis. When the patient entered the Presbyterian Hospital in January, 1894, the dermatitis involved more than one-half of the anterior surface of the abdomen. The treatment of this affection proved very tedious, so that two months later, when the operation was performed before the class of Rush Medical College, a patch of skin the size of the palm of the hand still remained in a state of intense irritation.

The same operation was performed as on the preceding patient, with similarly satisfactory immediate and remote results. Instead of constipation the operation was followed by diarrhea, which continued for several days, provoked probably by bringing the intestinal contents in contact with the colon, which had been almost completely excluded from the fecal circulation for five months. The wound healed by primary intention throughout. The dermatitis disappeared promptly after the removal of the cause. The patient left the hospital in perfect health four weeks after the operation. A study of these cases has convinced me that the provisional closure of the intestinal opening by transverse suturing before using the knife is the most efficient prophylactic measure against infection, and that resection of the intestine for fistula and artificial anus can be avoided in the majority of cases, and that in its place transverse suturing and correction of the flexion will yield better results.

PARTURITION PER RECTUM.—T. Spannochi (*British Medical Journal*) reports a case of extrauterine pregnancy, remarkable for the mode of its termination. A robust woman, without trace of disease of any kind, four months after a perfectly healthy labor, began to complain of pains in the hypogastrium. The symptoms pointed to an extrauterine pregnancy, probably in the left Fallopian tube. A month later the sac ruptured, and the fetus was discharged into the abdominal cavity. Reactive peritonitis around the foreign body came on; then followed suppuration and perforation of the intestine with discharge of pus. Owing to the continuous contractions caused by the presence of the foreign body the intestine became dilated and prolapsed; finally, after twenty-eight days, the fetus came away through the anus. Complete recovery took place.

SOCIETY REPORTS.

CHICAGO GYNECOLOGICAL SOCIETY.

MEETING HELD JUNE 15, 1894.

The President, Fernand Henrotin, M. D., in the chair.

The inaugural thesis, by Dr. Nicholas Senn, THE ETIOLOGY AND TREATMENT OF INTESTINAL FISTULA, was read. (See page 440.)

Dr. F. Byron Robinson: I am very much pleased with the presentation of the subject by Dr. Senn, and particularly with the conservative position he takes in treating these fistulæ. I have seen a good many fistulæ, and very few of them failed to close after the use of the probe and cautery. Some, however, required operation. Dr. Senn did not mention the flap-splitting operation of Colles, which I have seen Lawson Tait perform. Tait did not open the peritoneal cavity, as the fistulæ came up against the abdominal wall and adhesions occurred. With a small, sharp scalpel he encircled the fistula, separating the mucous membrane and skin. He used silkworm-gut sutures, as he does in his perineal flap operation. In the cases in which I saw him operate the results were splendid. All fistulæ are not appropriate for this operation. I think the remedies suggested by Dr. Senn are very good—that is, the thermo-cautery or nitrate of silver. I prefer the former. In using the cautery a good method is to push a little gauze down to the bottom of the fistula before applying the cautery, to prevent the danger of perforation of the intestine.

The operative treatment of intestinal fistulæ as given in literature has been very unsatisfactory. I have been convinced for several years that the best way to cure them is by the slow conservative method—that is, silver nitrate and the Paquelin cautery. A case of fistula came to me for laparotomy awhile ago from one of the city hospitals which was exceedingly burdensome to the patient. The patient was very much emaciated. I probed the fistula at intervals for about six weeks, when it was closed perfectly and she gained four pounds a week. I lost track of her four months afterward. I could mention a number of fistulæ which I have succeeded in ameliorating very much, and in some effected cure simply by probing with a uterine sound, which stimulated granulation. I think many fistulæ are considered intestinal that are secondary infection from the tubes affected with gonorrhea. I have closed abdominal incisions and hermetically sealed them, and yet six months afterward a fistula would appear. I have tried many methods of closing intestinal wounds. The Czerny suture, as I understood it in Czerny's clinic in Heidelberg, included only the mucous membrane. The Czerny suture acts best when it draws together all the coats of the bowel.

I want to study Dr. Senn's paper. It takes time to digest this subject, because intestinal surgery is not so frequent as some other branches of surgery. In my opinion the only way intestinal surgery will ever be brought into practical use will be through experimentation.

Drain tubes may cause fistulæ. I have in mind a curious experience relative to the drainage tube and fistula. About twelve days ago I assisted Dr. Waite in a laparotomy. Three days after the operation she attempted to remove the drainage tube, but could not get it out. It was a Keith glass tube. I was called up to assist her, and we found that a piece of intestine had extruded through one of the little holes and had become strangulated. I pulled up the drainage tube, and tied off and dropped back the long neck of strangulated gut. This is the first time I ever saw or heard of a piece of intestine going through one of the small holes in the Keith tube. The patient is doing well. In the case of the drainage tube I always have the nurse occasionally turn the tube around once or twice, but she must be cautioned to always turn it the same way. In this case I forgot to tell the nurse, and she turned it partly round and then turned it back again.

Dr. Weller van Hook: I have little to say on this subject, as Dr. Senn has, with his usual thoroughness, covered

the whole ground so fully that not much is left to be said. But I wish to express my admiration of the method he has used so successfully in preventing infection of the wound in this operation of closing large fistulæ. I have had experience with only two cases; in both I attempted to suture the opening, and failure resulted from lack of such precautions as Prof. Senn has used—that is to say, the preliminary transverse suture. Other methods, however, proved successful. It would seem that, with the close and firm transverse suture preliminarily placed, the abdomen might be opened almost without danger of infection and with permanent good results.

Dr. Fernand Henrotin: Three points of great importance were referred to by the essayist of the evening. First, the natural tendency of the great majority of these fistulæ to close. All who have had any experience in intestinal work recognize that a large proportion of these fistulæ, by cauterization, disinfection, and the usual methods employed, will be cured; thorough washing with peroxide of hydrogen is especially valuable. I have seen a number of cases cured quickly and well by this agent.

The second point is the value of the method Dr. Senn has proposed, and which I have not seen except in connection with Dr. Senn's work—that is, the transverse suture. The principle involved is the absolute closure of the wound in the intestine before opening the general peritoneal cavity. It is sometimes difficult, on account of the character, shape, size, and position of the fistula, to make a transverse suture. For example, one of the common intractable forms of fistula is the one appearing in the region of Poupart's ligament following an abscess after eradication of hernia. In these cases we sometimes have a long loop of intestine reaching up to a little opening around Poupart's ligament, and these fistulæ may last an indefinite number of years. The whole fistulous opening, including the small tract below the intestine, should be permanently closed before the general peritoneal cavity is opened. I have done two operations of this kind. The first case was quite successful; it was a recent fistula, apparently in the upper part of the jejunum. A few weeks after the hernia had been reduced an abscess formed, and colored fluid taken by the mouth would immediately appear at the opening; the patient was greatly emaciated. In this case I was compelled to reach in and bring the intestine very quickly to the opening in the middle line, and in that way managed to operate without infecting the general peritoneal cavity. The second case was of about ten year's standing, the attachments were strong, and it took so much effort to loosen them that I tore the bowel and contaminated the abdominal cavity, and the patient died. I can see how valuable Dr. Senn's method would have been in this case.

The third point of particular importance is the absolute value of drainage of the abscess. We are frequently able to cure the fistula by proper drainage of the abscess. It seems to me that in this class of cases, instead of performing laparotomy, if we make a vaginal incision and drain the abscess thoroughly and properly through the vagina, the fistulous opening will speedily close.

I take great pleasure in extending the thanks of the Society to Dr. Senn for his exhaustive paper.

Dr. Nicholas Senn, in closing the discussion, said: I simply rise to thank the members of the Society for the attention they have paid to the paper. I have carefully looked up the subject of the suture as a preliminary to the operation, but have found no allusion to it in the literature. It seemed to me that with the great mortality attending this operation, even in the hands of the most competent men, some change must be made, and it occurred to me that if the abdominal cavity were hermetically sealed and again disinfected the operation could be done under as favorable conditions as an ordinary laparotomy.

Dr. Samuel C. Beach presented (by invitation) A SELF-RETAINING PERINEAL RETRACTOR.

Gentlemen:—Having in view the inconveniences arising from the use of perineal retractors in the hands of assist-

ants, I have devised and had made a self-retaining perineal retractor, which I now present to your notice. The retaining mechanism consists of a flat band of metal, hinged about the centre for convenience in carrying, at one end of which an inlet has been made, the sides being approximated by means of a screw, thus holding firmly any object placed within their grasp. The retractor is an ordinary perineal retractor, but has the handle forked and turned at right angles to the plane of the blade, which is so bent on the handle as to hold back the posterior vaginal wall to the best advantage.

The retaining bar is held in place by being slipped under the body of the patient, who lies on the back with the thighs flexed on the body, thus making a fixed point of attachment for the retractor, which slips easily into the inlet in the retaining apparatus.

The patient being in position, the retaining apparatus in place under the body, with the end protruding over the edge of the table, the operator first slips the forked handle of the retractor into the inlet in the retaining apparatus, then with the two fingers of the left hand spreads the labia apart, inserts the blade of the retractor into the vagina, and, having pulled down the perineum sufficiently, turns the screw in the retaining apparatus tightly and is ready to begin operating.

This instrument has been tried in forty or fifty cases and has been pronounced satisfactory. It is light, easily handled, simple in structure, and easily sterilized. It has no complicated mechanism to get out of order.

With this instrument and a McBride-Packard yoke one can do a dilatation and curettement with only one assistant, the anesthetizer, thus making it a valuable aid in those cases of menorrhagia due to retained placenta in which the operation has to be done without delay.

Dr. H. P. Newman: I would like to testify to the efficiency of this instrument, having used it, under Dr. Beach's directions, in a single instance, with very decided advantage over the old method of having the aid of an incompetent assistant. It certainly is a great relief to have uniform traction kept up during the entire operation.

CORRESPONDENCE.

ANATOMICAL MATERIAL.

PHILADELPHIA, PA.,
Sept. 1, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—At the last meeting of the Association of American Anatomists, the undersigned committee was appointed to "consider the question of the collection and preservation of anatomical material, and to report, at the next meeting, what in their opinion are the best means of accomplishing these objects."

In order to make the work of the committee as comprehensive as possible, and to obtain information which will be of service in arriving at definite conclusions as to the best methods of accomplishing the purposes indicated in the resolution, the committee has deemed it desirable to send to the Teachers of Anatomy, not only in this country, but abroad, this circular letter, with the questions appended, and respectfully to request answers thereto, as fully as they can be made.

1. Is anatomical material obtained in accordance with a legal enactment, wholly or in part?

2. If there is an anatomical law in your country or State, please send a copy of it to the chairman of this committee, Dr. J. Ewing Mears, 1429 Walnut Street, Philadelphia, Pa. Please state whether the law is satisfactory, whether it is readily obeyed by those upon whom duties are imposed by it, and mention any improvements you would suggest, as to its requirements.

3. Is the material received in good condition?

4. What disposal is ultimately made of the remains?

5. Please state what means are employed to preserve anatomical material for the purposes of dissection or operative surgery. If injections of preservative fluids are used, state their composition and the methods of use, at

what point the injections are made, whether at the heart or in the large arteries, and their effect in accomplishing the preservation, with any changes in the color or character of the tissues. What length of time can material be used in dissection by the methods employed by you? If preservation by means of "cold storage" is employed, please state the cost of the machinery which it was necessary to construct for this purpose, and what means are taken to prevent decomposition after the subject is placed upon the table for dissection.

6. Please state the cost, by the method employed by you, for each subject, (*a*) for receiving it, (*b*) for injecting and preserving it.

7. Do you obtain an adequate supply of material for the purposes of anatomical instruction? How many students are assigned to each subject, and what is the method of allotment?

8. Please give any information which you may deem of importance. As the report will be general in character the name of the informant or institution will not be mentioned by the committee unless requested.

Your compliance with the request of the committee, *at an early date*, will be fully appreciated as rendering assistance to it in accomplishing its work, and it desires to thank you for the same in advance. Yours very truly,

J. Ewing Mears, M. D.,
Thomas Dwight, M. D.,
Joseph D. Bryant, M.D. } Committee.

Dr. W. K. Gowers says it is always a pleasant thing to be right, but it is generally a much more useful thing to be wrong. If you are right, all that you do, as a rule, is to confirm your previous opinion, your previous habits of reasoning, and your previous self-esteem. But if you are wrong you generally gain in knowledge and gain perception of the way in which your method of diagnosis needs improvement, and the influence on self-esteem is not likely to do you harm. At least that is my own experience, and I think I have observed it confirmed in others.

MEDICAL PROGRESS.

Perforation of the Uterus by the Curette.—The London *Lancet* contains an account of a paper by Dr. Auvard on the Relation of Curetting to Perforation of the Uterus. He considers that there is no one with an extensive experience of curetting to whom this accident has not happened on one or more occasions, though he believes that its occurrence is rare. Referring to his own practice, perforation of the uterus happened once in 270 cases of curetting. Dr. Auvard does not agree with the view commonly held that the perforation is produced by the curette itself, either in consequence of an extreme friability of the uterine wall, or from roughness on the part of the operator, or from both causes combined. He admits the possibility of this mode of origin, but thinks that in the large majority of cases the perforation is not caused by the curette itself but by the methods employed for the dilatation of the cervix preliminary to the curetting. In other words, the curette merely discovers the perforation. He then reviews the various means of dilating the cervix. There is the slow method of laminaria tents and the rapid method by which the cervix is dilated in a few minutes. The instruments employed for the rapid method are : (*a*) the three-bladed metal dilator of Sims, (*b*) the two-bladed metal dilator, and (*c*) Hegar's bougies. Dr. Auvard considers that the three-bladed dilator deserves the title of *le dilatateur-perforateur par excellence*, but that the two-bladed dilator is nearly as dangerous, and expresses the opinion that when the use of these instruments is discontinued, perforation of the uterus will disappear also. He expressly insists that these views are only to be taken as applying to the uterus apart from pregnancy or the puerperium. This being understood, it may be confidently said that rapid dilatation employed on a rigid cervix to the extent needed to admit the finger, whether by three-bladed or two-bladed dilators or by Hegar's bougies, will be followed in no small proportion of cases by a certain amount of laceration of the cervix, especially in the

neighborhood of the internal os uteri, and it is not difficult to see how easily a laceration may become a perforation. Incidentally, in the course of his paper, Dr. Auvard expresses the opinion that the best means of dilating the cervix in such cases is to begin with laminaria tents, and if sufficient dilatation has not been effected by their means, to complete it with a few sizes of Hegar's dilators. It is interesting to find that Dr. Auvard confesses he formerly objected to this method as being too cumbersome, but that a more extensive experience has now brought him to look upon it as the best.

* * *

Puerperal Infection from the Intestine.—Dumont (*British Medical Journal*) in a paper on "puerperal pseudo-infection of intestinal origin due to the bacterium coli commune," says this form of infection arises from changes in the intestinal mucous membrane inflamed through compression by the gravid uterus or through retention of feces irritating the coats of the bowel. These changes allow the bacterium coli to pass into the peritoneum, setting up infection, which is intestinal and not, strictly speaking, puerperal in origin. The symptoms usually appear about a week after delivery, the patient doing well at first, but being troubled with obstinate constipation. The temperature and pulse rise very high, the face looks pinched, the tongue is rough, the breath fetid. The mental condition remains normal, and even the appetite may be good. There is tenderness over the cecum, transverse colon, and sigmoid flexure. Sometimes a flabby mass can be felt touching the uterus, but separable from that organ. The uterus and fornices feel free on palpation, as in many cases of true puerperal infection. The result is very uncertain. At least the course of the disease is different from that of enteric fever. In mild cases the symptoms disappear after the action of a purge; in other instances the patient dies within a fortnight; in others again she may remain ill for over six weeks and yet recover. The usual sequelæ of infections have been known to follow, such as phlegmasia dolens, arthritis, ulcerative endocarditis, and salpingitis. An important complication, observed by two obstetricians, is paralysis, caused by central myelitis; this explains the great frequency of paralysis of the intestine, which involves further retention of the irritating scybala and greatly aggravates the disease. Dumont believes in the prophylactic treatment of this kind of infection. The bowels should not be allowed to become constipated during pregnancy. Laxatives and enemata during childbed are imperative from the first. Seven cases of intestinal infection are described.

* * *

Treatment of Pleuritic Effusions.—Pleuritic effusions are due to some disorder of the cell-plates of the pleura whereby effusion takes place. This disorder may be tubercular or it may be due to other causes. Dr. Thomas G. Ashton says in the *Therapeutic Gazette* that because some cases are tubercular we must not think that all are and we should not forget that rheumatism is frequently a cause of this trouble. He concludes :

1. That the tubercle-bacillus is the cause of the majority of cases of pleurisy.

2. That a certain number of cases of pleurisy are due to rheumatism.

3. That in the treatment of the rheumatic cases we should employ the salicylates, as having specific action in such cases.

4. That the salicylates are of value in cases of other than rheumatic origin, and their use, therefore, should not be restricted to such cases.

5. That, as a rule, purulent effusions demand evacuation and free drainage.

* * *

Compound Fractures.—Railway surgery is at present forming a large part of the surgeon's work, and it is of a kind that demands quick judgment and prompt decision. Dr. Milton Jay says in the *Railway Surgeon* that it is worse than useless to attempt to adjust a fracture for permanent treatment in an infected wound. Clean this wound first and set the fracture later. It is very important to know whether to amputate

or not. If the principal blood vessels are intact amputation may not be necessary. In short, follow these rules:

1. Thoroughly cleanse the wound, and render it aseptic.

2. To decide as to whether or not you will amputate the limb.

3. To secure, if possible, early union of the soft parts regardless of the fracture.

4. The best mode of securing fixation of the fractured fragments, provided this is necessary.

5. If the wound is infected, the best mode of treatment.

6. The best appliance for immobilization of the limb during bone union.

* * *

Operative Treatment of Gastric Ulcer.—Küster (*British Medical Journal*) reports a case of successful operative interference for profuse and repeated bleeding from an ulcer of the stomach. The patient, a woman, aged 21 years, after over-exertion in lifting a heavy body in 1889, suffered much from abdominal pain and vomiting, and subsequently lost flesh. In 1891 she was treated for dilatation of the stomach and floating kidney on the right side. Nephrorrhaphy was performed, but gave only temporary relief. In October, 1892, there occurred severe and frequently repeated attacks of bleeding from the stomach, by which the patient was much pulled down. In August, 1893, laparotomy was practiced and the stomach exposed. After this organ, which was much dilated, had been opened, a large and deep ulcer with undermined edges, at the bottom of which a cherrystone could be seen, was found on the posterior wall near the pylorus. The surface of this ulcer, which adhered very closely to the pancreas, was then burnt with the thermo-cautery, and, as the opening into the duodenum was so small that it could not be found, gastro-jejunostomy was performed, the opening between the stomach and intestine being about 2½ inches in width. The patient made a good recovery, and, when last seen, was able to work and to take her usual food. There had been no return of the bleeding. The author draws the following conclusions from this case: 1. The hemorrhage from a gastric ulcer may be arrested by a single application of the actual cautery. 2. That in cases of gastric ulcer situated near the pylorus, gastro-enterostomy is preferable to pyloroplasty, as the latter will not prevent the bad results of cicatricial contraction and stenosis. 3. That a wide anastomotic opening between the stomach and intestines so far from being disadvantageous, will ensure the patient against the risks of subsequent constriction along the line of sutures.

* * *

Kraurosis Vulvæ.—Dr. Charles A. L. Reed protests in the *New York Medical Journal* against this name invented by Breisky for the term progressive cutaneous atrophy of the vulva. Its history is very recent, the etiology is obscure. Some have referred it to syphilis, others to gonorrhea, but Dr. Reed thinks these troubles are simply accidental and he finds no true cause for this condition. From his study of cases he concludes:

1. Progressive cutaneous atrophy of the vulva (kraurosis vulvæ) is a distinct disease.

2. It is of very rare occurrence.

3. It is essentially inflammatory in character, differing from other inflammations of the skin in the marked progressive atrophy which succeeds the stage of hyperemia and infiltration.

4. It is limited in its manifestations to the vulva.

5. It is manifestly not of syphilitic origin.

6. Its etiology is so obscure as to suggest a primary causal lesion in the trophic-nerve supply to the vulva.

7. Affected areas may be successfully excised.

* * *

Potassium Permanganate in Morphia Poisoning.—Ever since Anthal, an Alsatian chemist, claimed that potassium permanganate was an efficient antidote to a number of alkaloids, as well as to phosphorus and oxalic acid, and Dr. Moore of New York showed its efficacy in morphia poisoning, physicians

all over the world have been making practical and successful use of this antidote. Dr. Graham Chambers of Ontario brings out some new facts on this point in the *Canadian Practitioner*. He performed certain chemical experiments in the laboratory and also physiological experiments on animals, and from these he concludes that:

1. Potassium permanganate in dilute solution, not stronger than one grain to an ounce, may be given by the stomach without danger.

2. Potassium permanganate, subcutaneously, is poisonous.

3. Potassium permanganate, grain for grain, completely decomposes morphia, the decomposition occurring in acid media more rapidly than in a neutral medium.

4. Foodstuffs and acetic acid do not interfere with the decomposition.

5. Potassium permanganate is an efficient antidote if taken while the morphia is in the stomach.

The question still remains as to whether potassium permanganate is of therapeutic use after the morphia is absorbed into the system. It has been proved conclusively that if morphia is introduced subcutaneously into the system it is excreted into the stomach. Now, the morphia passes from the blood into the stomach by osmosis and by excretion, and, by the principle of osmosis, more morphia will be excreted if it is decomposed as soon as it passes into the stomach. Reasoning on this principle, we would expect that repeated small doses of potassium permanganate by the stomach would be of use in cases where the morphia has been absorbed into the system. This is rendered more probable by the fact that morphia, as a rule, is a slow-acting poison.

* * *

Sea Air in Disease in Children.—Leroux (*British Medical Journal*) argues that sea air should not be indiscriminately advised for children. He considers that it is apt to have an injurious effect in cases of heart disease and hereditary syphilis. It is of use in anemia except in rheumatic or neurotic patients. As a rule it is of advantage in lymphatic children, but not in those who are highly irritable or liable to inflammatory complications. Scrofulous children suffering from chronic inflammatory complications, chronic conjunctivitis or otorrhea, hypertrophy of the tonsils, or chronic cutaneous affections should be sent to the seaside unless it is known that they are liable to acute inflammatory exacerbations. On the other hand, weeping eczema, acute impetigo, pruriginous skin affectons, and acute painful ear disease are contraindications. Children suffering from chronic tuberculosis of bones or glands do well at the seaside, unless there is copious suppuration. Pulmonary tuberculosis is always a contraindication, and the propriety of sending children with enlarged abdominal or thoracic glands is very open to question. As a rule lupus does not do well. Rickets, if the children are sent at an early stage of the disease, is cured by continuous residence at the seaside for a year or more.

* * *

Rupture of the Uterus.—In the London *Lancet* Dr. Loin records two cases of rupture of the uterus. The chief dangers that threaten the patient when this accident occurs are hemorrhage and septicemia, and therefore it is more especially to combat these that any treatment likely to prove successful must be employed. Dr. Loin's first case was one of transverse presentation in a multipara aged twenty-seven. The membranes had been ruptured three days when the patient was seen, and the uterus was tonically contracted; nevertheless, Dr. Loin easily performed podalic version and extracted a decomposing female child. The placenta was removed with the hand. A complete vertical tear of the posterior wall of the lower segment about eight centimeters long was then discovered. There was a good deal of hemorrhage at this time. A Sim's speculum was passed, the cervix was seized with volsellæ, and a thick roll of iodoform gauze was packed into the uterus with the object of arresting the hemorrhage partly by its direct pressure and partly by exciting the uterus to contract. Another strip of iodoform

gauze was passed through the rent in the uterine wall into the peritoneal cavity. A firm compress was also placed on the hypogastric region. The patient seems to have done pretty well till the fourth day, when the intra-peritoneal plug of iodoform gauze was changed. While this was being done hemorrhage recurred, and the patient died the same evening. In the second case rupture of the uterus occurred during the process of extracting a fetus at the fourth month of pregnancy. The diagnosis of rupture was here made by passing the sound, which entered for its whole length, and by ascertaining that the distal end was obviously in the cavity of the peritoneum. In this case, as in the other, two plugs of iodoform gauze were used, one to plug the uterus, the other being passed through the rupture into the peritoneum. Here the gauze plug in the abdomen was not touched for "many days," and the patient recovered. The treatment described seems well worth trying in cases of rupture of the uterus where the fetus and placenta have been removed per vaginam. The manipulations necessary to carry out Dr. Loin's method have the advantage of being simple and adding little to the existing shock, at all events as compared with any measures involving an abdominal section.

* * *

The Vagus and Gastric Acid Secretions.—Leubuscher and Schäfer (*British Medical Journal*) first referred to the investigations of Pawlow and Schumova in this subject. Their views were subsequently confirmed by Krehl, who showed that after section of both vagi below the recurrent laryngeal nerves, the animals wasted, lost their appetite, and died. No free hydrochloric acid was found in the stomach, and the gastric juice possessed little digestive action. The authors have themselves experimented on rabbits and dogs. In the former no effect upon the secretion of acid was apparent, but these animals are hardly as suitable as dogs for this investigation. The general symptoms presented by the dogs corresponded to those seen by Krehl. No distinct effect upon the secretion could however be made out. The different degree of acidity which was noted in the peripheral and central portions of the stomach contents is best explained by the paralysis of the stomach wall due to the division of the vagi.

* * *

Athetosis and its Pathology.—In *Virchow's Archiv* Professor Eichhorst has a contribution on this subject, which is abstracted in the London *Lancet*. Two cases are considered, and in one of them a necropsy was obtained. Both patients were affected on the right side, and the affliction dated from childhood. In one, besides the fingers and hand, the face also was affected, as well as the muscles of the lower jaw—a very unusual condition. In this case also there were occasional tonic muscular contractions, which caused a temporary cessation of the athetotic movements. In the second case nothing unusual was present as regards its clinical aspect. At the necropsy a cyst about the size of a walnut was found in the left lenticular nucleus, extending on one side into the internal capsule and on the other into the external. In a critical consideration of the recorded cases of athetosis with necropsy the writer finds that in the great majority of cases the lesion is found in the optic thalamus or corpus striatum, and the characteristic movements are presumably evoked by the irritating effects of the lesion on the adjoining pyramidal tracts.

* * *

A New Surgical Work.—*A System of Surgery*, edited by Frederick S. Dennis, M. D., and John S. Billings, M. D., is announced by Lea Brothers & Co. as shortly to appear, in three imperial octavo volumes. The list of contributors embraces such names as W. T. Bull, Charles McBurney and Robert F. Weir, of New York; Councilman, Porter, Richardson and Warren of Harvard; Carmalt, of Yale; Keen, White, Roberts and Wharton, of Philadelphia; Welch, of Baltimore; Park, of Buffalo; Conner, of Cincinnati; Mudd, of St. Louis; and Senn, of Chicago.

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BALTIMORE, OCTOBER 6, 1894.

Decision Involving Autopsies.

In this "land of the free" where suits are brought and injunctions served on the slightest provocation and almost "while you wait," as the cobbler says, it is not surprising that physicians individually or as a teaching body should come in for their share.

The recent case of Barbara Young *vs.* the College of Physicians and Surgeons, Nathaniel G. Keirle, M. D., and Edwin Geer, M. D., which has just been decided in favor of the defendants, has excited much interest among the profession. The facts upon which the suit was based are these: In March, 1893, the husband of Barbara Young, while discharging his duties as a brakeman in the employ of a railroad, met with an accident by means of which his right leg was crushed off just below the knee.

The patient was sent to the City Hospital (which is controlled by the College of Physicians and Surgeons), the injured limb was carefully dressed and the patient put to bed. The shock was so profound that in spite of the most persistent efforts it failed to yield to treatment, and after 36 hours he died, no operation having been performed. The police authorities were at once informed of the death and Dr. Edwin Geer, the coroner, was sent to investigate the case. Dr. Geer is connected with the City Hospital as Superintendent of the Dispensary. After inquiry, the coroner ordered Dr. Keirle, the post-mortem physician of the city (and Professor of Pathology in the College of Physicians and Surgeons), to perform an autopsy and report the cause of death to him.

Two months after the interment, Barbara Young had the remains of her husband exhumed and finding that a post-mortem examination had been held without her sanction, at once instituted a suit for $25,000 against the College and Drs. Keirle and Geer. The plaintiff's claim was that the coroner acted beyond his authority in ordering a post-mortem; that Dr. Keirle, the post-mortem physician, had no right to obey an illegal order; that he wantonly mutilated the body of the deceased, robbed him of his brain, stuffed the skull with oakum, and sewed up the cadaver with red twine, and that the action of both coroner and post-mortem physician was due to their connection with the College of Physicians and Surgeons, upon whose property the autopsy was made.

The case was presented with great force before the Honorable Judge Phelps and jury. The judge granted the prayers of the defendant as applied to the College and coroner, ruling that the College could not be held liable for damages to which it was not a party; that Dr. Geer acted in his capacity as coroner and in a judicial capacity; that so far as Dr. Keirle's action as the post-mortem physician was concerned he could only be held liable for such damages as might accrue from exceeding the requirements of a legal post-mortem. That if he unnecessarily mutilated the body, or left it in such a condition as to be revolting to the widow and family, then the jury might find damages for such wanton mutilation.

The jury's verdict exonerated all the defendants. The decision given establishes, so far as it goes, the right of the coroner to decide when an autopsy shall be held; that his office is judicial and not merely ministerial. It is a matter of rather frequent occurrence to

find coroners certifying to deaths as accidental without actually ascertaining the cause of death provided criminality is not apparent in the case. By so doing of course some personal popularity may be gained, and many valuable observations which might ultimately lead to good are sure to be lost. Still, autopsies are not often performed in private practice, for very evident reasons, and it is hardly to be expected that any physician would so run counter to his own interests and the family's feelings; yet it should be borne in mind that in suspicious cases the coroner may be summoned to satisfy justice as to the cause of death. This decision is greatly to the credit of the jury, who clearly saw that a woman who could stand by the two-months old grave of her late husband and personally see and superintend the exhuming and examination of the body could hardly with justice claim damages for "mental anguish" from an ordinary autopsy.

The decision in this case may be considered as sustaining the right of the coroner to order such examinations when not absolutely certain as to the cause of death.

* * *

Oral Pathology.

However far a specialty may separate itself from general medicine, it can never become entirely disconnected. The specialist ought and often does remember other organs outside of his own department, but he most often does not.

An oculist once wrote an article on what the general practitioner should know about eyes, to which the general practitioner replied with a paper showing what the oculist should know about general medicine. The specialty of dentistry is supposed to be farther away from medicine than any other branch. This is shown in part by the fact that there exist dental schools where dentistry is alone taught, a thing which this specialty of all others alone enjoys.

Still, physicians should remember the close connection between the care of the teeth and mouth and the general health of the body and this Professor W. D. Miller of the University of Berlin showed last Monday night at the Johns Hopkins Hospital. Dr. Miller, an American and a graduate of Ann Arbor University and also of a dental college, went to Europe about fifteen years ago and by hard work and from small beginnings has built up a large practice in Berlin, and is perhaps the only native born American who holds the position of Professor at a German University. Ever since the revolutions in bacteriology by Koch, Dr. Miller has given careful attention to the organisms of the mouth and recognizing that the mouth and nose are the principal avenues through which many diseases are introduced into the body, he has worked out results of great value.

He has found so far thirty-two distinct varieties of organisms in the mouth and around the teeth. He has found the cause of decay and in his lecture he showed some photomicrographs which are perhaps unexcelled in their clearness and amplification, photographs in which Dr. Miller is an adept.

He not only showed the organisms which are rarely absent even from a healthy mouth, but also the accidental organisms, such as those of pneumonia, which are so often present in the saliva and which have such virulent and toxic effects in some cases. He explained, also, the influence which decayed and diseased teeth have on neighboring organs and glands in the body and related several cases in which attention to oral defects resulted in a cure. Added to this he gave some practical directions for preventing collection of tartar and decay and showed the necessity of using the tooth-brush with an occasional antiseptic.

The care of the mouth and teeth is a very important part of the healing art and for the nurse especially is such information as Dr. Miller gave of great value.

* * *

The Winter's Work.

The medical schools have opened their doors and their winter work has begun in earnest and now the medical societies will take up the thread of last year's deliberations and the physicians of the cities and counties will once more meet together and profit by mutual experience. Some will have elaborate papers, some reports of cases, others will have taken an intelligent part in the discussions, while the rest will do their parts by listening. Each member of the profession should start the new year with resolutions to support the medical societies, for they reflect on the surrounding cities and countries the knowledge and skill of the members and show a class of men awake to scientific as well as pecuniary interests.

MEDICAL ITEMS.

The various city and county medical societies begin their work this month.

Dr. William Goodell is said to be recovering from the attack of paralysis received several weeks ago.

Dr. D. K. Shuter of Washington, D. C., has been appointed visiting physician to the District of Columbia jail.

Dr. Robert Tunstall Taylor of Maryland Avenue has removed to Boston, where he has received a hospital appointment.

Dr. John Whitridge Williams has taken the house and offices at the south-east corner of Park Avenue and Richmond Street.

Dr. S. Griffith Davis has taken the office corner of Madison Avenue and Biddle Street, formerly occupied by Dr. P. C. Williams.

Dr. Robert B. Morison, after an absence of almost a year, has returned to the city and will resume his practice in dermatology at 827 St. Paul Street.

Dr. I. S. Stone of Washington, D. C., has secured the house at 1449 Rhode Island Avenue, and will open a private sanitarium for gynecological cases.

At the last meeting of the Johns Hopkins Hospital Medical Society, Dr. Samuel Theobald was elected president and Dr. J. G. Clarke secretary.

Dr. Howard A. Kelly will remove his offices to 1406 Eutaw Place in order to be near his private hospital, which at present occupies two large houses on Eutaw Place.

Dr. Hiram Woods, Jr., has been appointed Lecturer on Ophthalmology and Otology in the University of Maryland and will lecture this year in the place of Professor J. J. Chisolm.

Dr. William Osler returned from Europe last week. He attended the meetings of the British Medical Association and the British Association for the Advancement of Science.

The Pure Food Exposition which will open in Baltimore next Monday should be visited and studied by all physicians and nurses. Similar expositions are in progress in London, Boston and Chicago.

An enterprising firm in New York has established a private ambulance service for the convenience of small hospitals and physicians in private practice. Baltimore has no genuine ambulance service in use, either public or private.

As soon as the Faculty of the College of Physicians and Surgeons have completed arrangements they will sell the old Maternité on West Lombard Street and put up a model lying-in hospital near the City Hospital.

The Medical Society of the Woman's Medical College held its first meeting of the season last Tuesday night. Many interesting papers were presented. The Clinical Society of Maryland also held its first meeting on Friday night, and elected officers for the ensuing year.

The Journal of the American Medical Association moved into its handsome new home at 86 Fifth Avenue, Chicago, without the slighest friction or delay in issuing the Journal. The new presses do good and rapid work. The management deserves great credit for this change.

Mr. Charles J. Wells of Hartford, Connecticut, the only living descendant of Dr. Horace Wells, the discoverer of anesthesia, is arranging to celebrate the fiftieth anniversary of his father's great contribution to surgical practice. A bronze tablet will be placed on the site of the discoverer's house.

The University of Maryland Medical Society will hold its first meeting of the season in the Faculty room in the University building, corner of Lombard and Greene Streets, next Tuesday, October 9, 1894, at 8 P. M. All graduates of the University and members of the teaching staff are invited to be present.

The managers of the new State insane asylum have returned from an inspection of the buildings at Poughkeepsie which are constructed on the cottage plan. Dr. George H. Rohé, who was one of the party, reports that they were much pleased with the buildings there and as soon as a site can be selected here buildings on a similar plan will be constructed.

The *Western Reserve Medical Journal* says: Dr. W. T. Howard, Jr., who comes to us this year from the Johns Hopkins University, is a graduate of the University of Maryland, in 1889. He brings with him a thorough training and a great deal of enthusiasm for his work in pathology. Dr. William T. Howard, Jr., is associate professor of pathology at the Western Reserve University and not associate in pathology, as stated in a former number.

BOOK REVIEWS.

A TREATISE ON APPENDICITIS. By George R. Fowler, M. D., Examiner in Surgery, Medical Examining Board of the Regents of the University of the State of New York, etc. Philadelphia: J. B. Lippincott Company, 1894. Pp. 16–17 to 190. Price, $2.

This work by Dr. Fowler of Brooklyn, N. Y., is a modest volume of 190 pages, which first appeared in the *Annals of Surgery*, as a serial, in January, 1894. It is a complete treatise upon the subject, and is especially valuable as embodying the ripe clinical experience of the author, derived from the treatment of 200 cases of this dangerous disease. Whilst doubtless appendicitis was as frequent in former times as at the present, the nature of the affection was not recognized, and many cases were supposed to be idiopathic peritonitis, or perityphlitis, and died or got well without any accurate diagnosis having been made. The importance of the subject can scarcely be overestimated, since the disease is now known to occur with great frequency, and to yield satisfactory results to prompt treatment, and on the contrary to present a large death-rate when neglected. Dr. Fowler has therefore done the profession a service in preparing a monograph upon this subject, and in clearly and concisely describing its whole history. The book is well illustrated with wood cuts, and with several colored lithographic plates. Dr. Fowler is an earnest advocate of early operative treatment, and believes that "a case which is not practically well at the end of twenty-four hours should be made the subject of operative interference."

ATTFIELD'S CHEMISTRY. Fourteenth Edition. Chemistry, General, Medical and Pharmaceutical; Including the Chemistry of the U. S. Pharmacopeia. A Manual of the General Principles of the Science, and their Application to Medicine and Pharmacy. By John Attfield, M. A., Ph. D., F. I. C., F. C. S., F. R. S., etc., Professor of Practical Chemistry to the Pharmaceutical Society of Great Britain, etc. Fourteenth edition, specially revised by the Author for America to accord with the new U. S. Pharmacopeia. In one handsome royal 12mo. volume of 794 pages, with 88 illustrations. Cloth, $2.75; leather, $3.25. Philadelphia: Lea Brothers & Co., 1894.

It is hard to say much on a book which has run through fourteen editions in America and fifteen in England. The present work has been brought down to date.

CURRENT EDITORIAL COMMENT.

CARE IN ANESTHETIZING.

Medical Record.

HABITUAL good luck engenders carelessness; but there is no more striking example of the inconsistency of human nature than the fact that, while modern surgery demands the most scrupulous attention to details with regard to the preparation of the patient and the technique of the operation, there has been no corresponding improvement in this country in respect to the administration of anesthetics.

THE SPREAD OF DIPHTHERIA.

Medical News.

IT is perhaps no exaggeration to say that far more harm comes from the spread of diphtheria through mild cases, either not recognized or not reported and not isolated, than from the very malignant cases, for of these latter there is a popular fear, and they are summarily dealt with. It would, therefore, appear that health boards could do far more good by instituting some means by which an accurate diagnosis could be made at once, and suitable measures in accordance therewith promptly adopted, than by detailing one or more men to watch a house harboring a malignant case of diphtheria, or by sprinkling carbolic acid in the back-yard and cellar of a house in which a case of ordinary severity develops.

REST FOR PHYSICIANS.

Medical Summary.

THE physician needs more mental diversion. He needs more active exercise; and more sleep, too—fully seven hours—and as his sleep is often broken in upon at night, he should form the habit of sleeping at odd moments, even by day. The folly of incessant work is illustrated by the case of the brilliant Dr. Golding Bird, of London, who a few months before his death remarked to a medical friend, when his own great popularity was mentioned: "You see me, at a little over forty, in full practice, making my several thousand pounds per annum. But I am to-day a wreck. I have a fatal disease of the heart, result of anxiety and hard work. I cannot live many months, and my parting advice to you is this: never mind at what loss, take your annual six weeks' holiday. It may delay your success, but it will insure its development. Otherwise you may find yourself at my age a prosperous practitioner, but a dying old man."

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NOTES.

INHALATIONS of oxygen has saved life in morphia poisoning.

*

DERMATOL is recommended as one of the best and safest drugs in the treatment of diarrhea.

*

FREQUENT small doses of tincture of nux vomica are recommended during severe asthmatic attacks.

*

DERMOL used in ointment is a new skin remedy. It is made by treating a bismuth salt with chrysophanic acid.

*

PILOCARPINE used hypodermically until its physiological effects are produced has been successfully employed in erysipelas.

*

ANTISPAMIN, consisting of sodium narceine and sodium salicylate, has been suggested as a good remedy in whooping cough.

*

THE French have been very successful in the treatment of actinomycosis in man and animals by using large doses of the iodide of potash.

*

DR. CHARLES E. PAGE of Boston says that the best remedy for cough he has ever found is a teaspoonful of moderately hot water, taken every time a paroxysm of cough comes on.

READING NOTICES.

IN prescribing the products of manufacturing pharmacists, we should be guided to a great extent by the business standing of the manufacturers. No other house in the South or West has a better reputation for strict integrity than the Robinson-Pettet Company, Louisville, Ky.

*

Celerina.—In the varied conditions following the abuse of alcohol, opium, and tobacco, to restore the patient and tone the nervous system, Celerina is of great value, and as a tonic to the nervous system in all these cases of nervous exhaustion, whether evolved in the cerebral or spinal centers. Celerina, in doses of a fluid drachm three times a day, destroys the craving for alcoholic liquors.

*

Listerine.—Taking into consideration the component parts of Listerine, it impresses me favorably as a prophylactic and remedial agent for cholera, along with other intestinal disturbances. The eucalyptus, thyme, gaultheria and boracic acid which it contains are all antagonistic to germ life and oppose fermentation. The preliminary diarrhea (cholerine, as it is called) may well receive teaspoonful doses of Listerine combined with the same amount of glycerine; in fact this combination is recommended to the laity as a prophylactic measure.

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Superintendent Chas. Ainge, of the National Detective Bureau, Indianapolis, Ind., announces that two or three capable and trustworthy men are needed in this county to act as private detectives under his instructions. Experience in the work is not necessary to success. He edits a large criminal paper and will send it with full particulars, which will explain how you may enter the profession by addressing him at Indianapolis, Ind.

*

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ORIGINAL ARTICLES.

HEMATEMESIS NEONATORUM.

By John S. Fulton, M. D.,
Salisbury, Md.

The appearance of blood or bloody ejecta about the mouth of an infant is to the lay observer always alarming, and those of us who have never failed to discover a promptly remediable cause for the phenomenon have been so far fortunate.

Now and then an infant, in apparent health, vomits a little blood without nausea, and a few hours later yields up its life to gastro-intestinal hemorrhage. In the subsequent report to the Society or the Journal one may perhaps discern the aroma of clinical consternation.

Reviewing the periodical literature of pediatrics with reference to this point, it is found that vomiting a little blood is not unfrequently the initial symptom of fatal disorder.

The emesis of infancy is so usually an easy physiological process, that, unless nausea is pronounced, or the ejecta are anomalous, the act receives no particular attention. When blood appears, its source is usually not very recondite, and its prognostic significance happily not grave. The new-born babe may have swallowed maternal blood, in which case the hematemesis will disappear after one or two regurgitations; or the maternal nipples may yield blood as well as milk. I know a mother, one of whose breasts, to all appearance normal, has habitually furnished blood at the beginning of several lactation periods.

These facts suggest that the inquiry in all cases will be well begun by learning first whether the matter vomited is really blood, and if so, whether it is the blood of the infant. Having settled these points, a large field of inquiry may remain to be covered before our diagnostic sense shall be satisfied.

Here let us recall the peculiar physiology of the vascular system and of the blood. In the infantile arteries the elastic tissue is thin, and sends few fibres into the muscular coat, which on the other hand is well developed. This tenuity and separateness of the elastic membrane is most marked near the arterial branches.

The intima is so slightly developed as to be scarcely demonstrable except in the larger arteries. Although the heart at birth bears its largest ratio to body weight (1:120), arterial pressure is low. Thus the vascular feebleness, favorable to hemorrhage, is compensated by a due adjustment of tension.

The blood of infancy is relatively poor in fibrin and in salts. It is therefore less coagulable than that of adults, a fact often lost sight of by clinicians who invoke the hemorrhagic diathesis to explain uncontrolled hemorrhage in children.

The surface vessels of the mouth and fauces are very accessible to traumatism. The manipulations of the nurse may inflict injuries which bleed through the abrasions and escape detec-

tion. In the same way, the rubber nipple, which so often contents the child in the intervals of nursing, may set up a hemorrhage. The posterior pharyngeal wall sometimes bleeds when the vessels have, so far as can be ascertained, received no greater violence than accompanies the act of suckling. We may have here a true "hemorrhage by exhalation" and all efforts to localize a lesion may be utterly baffled.

As in adults, hematemesis must be differentiated from hemoptysis, with the added difficulty, that in infancy blood will rarely appear at the mouth without admixture of matters from the stomach. A bleeding from the respiratory tract, expressing itself by frank hemoptysis, would probably be so fatal an event, that diagnosis would be the only service one could render in the case. The ordinary exponent of lung hemorrhage in children is hematemesis, and its diagnosis involves inquiry as to phthisis, heart lesions, pulmonary embolism and apoplexy.

A true gastrorrhagia may result from atelectasis. Doubt upon this point has been expressed by various observers, but in view of the normal delicacy of the vascular organization in infancy, and remembering how often this condition amounts to arterial incompetency, it seems to me that the reasonableness of this view must be admitted. The greater or less venous stasis, due to imperfect respiration, may determine hemorrhage as easily in the gastric as in any other area. Gastrorrhagia may also be an incident of scorbutus, of hemorrhagic purpura, or of syphilitic hepatitis.

Melena neonatorum is a term somewhat loosely applied to all cases of gastro-intestinal hemorrhage occurring in infants. It is a term expressive of no pathology, and will doubtless pass out of scientific use as continued observation separates the cases so described into distinct groups. Modern advance into this particular region of pathology has developed much that is both of interest and value. The great change in the vascular mechanism, which is initiated at birth, renders the infant organism peculiarly liable to the accidents of embolism. These dangers are only partially provided against by the low pressure and relatively less coagulability of the blood. Thrombi derived from the umbilical vein may set up mischief in almost any direction, and may give rise to gastrorrhagia in either of two ways: by obstructing portal circulation; or by invading the gastric area and there producing ulceration precisely as the same cause produces gastric ulcer in the adult.

No period of infancy is exempt from gastric ulcer, nor is the affection so rare that the clinician may disregard it. A large number of cases have been seen in infants of from seven to fifteen days, dead of melena.

Sawtell found multiple gastric ulcer in a babe who vomited blood at 21 hours and died of gastro-intestinal hemorrhage at 48 hours old.

He thought that obstructed portal circulation and peptic erosion accounted for the condition found.

The role of embolism in such cases has not yet been definitely ascertained, but thrombosis of the umbilical vein has been observed, and while the ductus arteriosus and ductus venosus remain patulous the rest is easy.

It must not be forgotten that gastro-intestinal ulceration may be congenital (Cartiaux, 1857). Such a case could have no relation with the birth change, but would not be therefore necessarily independent of embolism.

Quite recently (1894) Gärtner claims to have obtained in pure culture a short, actively mobile, gas-producing bacillus, which being applied to the umbilical stumps of new-born puppies caused death by melena. To this von Preuschen replies that Gärtner has only produced a hemorrhagic peritonitis by his inoculations, and promises to demonstrate, in a paper soon to be published, that brain injury received during parturition is the true cause of melena neonatorum.

Undoubted septic umbilical phlebitis brought death from hemorrhage to a patient of Petersen in 1882.

Herrgott (1894) delivered by version the tenth child of healthy parents. Ten hours after birth the boy died of gastric

hemorrhage. Autopsy revealed arrested development of the left heart, and from this anomaly to atony of the gastric arterioles and passive hemorrhage each step is clearly traced. The mother asserted that two previous children had died in the same way.

Fortunately for humanity, but to the discomfiture of pathologists, a case of melena neonatorum occurs but once in about 2000 births.* Nevertheless we have in this brief study seen enough to safely conclude that future investigations will replace the term melena by a group of diseases, differing essentially from each other, though presenting similar clinical manifestations.

A remotely possible cause of gastrorrhagia is cancer, of which a case was seen in an infant of five weeks by Cullingworth in 1877. Other cases are recorded, but this one, besides occurring in the youngest subject, is the best attested, the growth having been demonstrated a cylindrical-celled epithelioma.

Dr. Bache Emmett reported to the New York Obstetrical Society in 1891 a case in which, during the administration of ergot to a mother for recurrent postpartum hemorrhage, spots of blood appeared upon the lips and clothing of the child and tarry stools were passed. These symptoms continued during the medication of the mother and ceased upon the withdrawal of the drug.

The treatment of hematemesis neonatorum is based upon the general principles of hemostasis modified by whatever knowledge can be obtained as to the cause and source of bleeding.

Vascular lesions in accessible situations will be treated locally. Hemorrhage from the posterior pharyngeal wall, mouth or fauces is aggravated by the act of sucking, so that it will be wise in such a case to feed the infant with a spoon for a time.

The most important therapeutic measure against true gastrorrhagia is rest.

All drugs which increase arterial tension must be avoided, and in the selection of astringents great respect must be paid to the danger of exciting nausea.

*Genrich 1—1000, Dussu 1—1000, Hergott 1—1500, Leopold 1—4000.

Hamamelis is very effectual and easily administered. The milder astringent failing, Monsell's solution may be safely given in one or two drop doses diluted with a little water. The favorable moment for the use of styptics or astringents is immediately after vomiting, when a period of absolute rest and abstinence from food should, if possible, be secured.

If nausea is present, constituting in infants a hyperemesis, gastric sedatives are indicated. Aconite, as suggested by Hare, is one of the best. When the nausea must be attacked through the cerebral centers, the bromides are best administered by rectum. Counterirritation by mustard or spice plasters over the abdomen is helpful.

In case of profound exhaustion or collapse from loss of blood, external heat is to be applied, and hypodermoclysis of the physiological salt solution may be practiced. The subcutaneous infusion is probably better than transfusion, for in practicing intravenous injection, besides the technical difficulties, one must bear carefully in mind the inherent weakness of the vascular structures, and the danger of too great or rapid rise of blood pressure.

If in any case the existence of gastric ulcer seems probable, rectal feeding should be employed for the sake of physiological rest to the stomach.

The only measure preventive of gastrorrhagia which our studies so far would seem to suggest is a mode of dealing with the cord, strictly scientific both as to the time of cutting and the manner of dressing. This opens up the oldest of all surgical subjects, and one well worthy of a modern article. Its importance, like that of hematemesis neonatorum, is best realized by those who, not unmindful of the usual, adapt their procedures to the unlikely; who prepare resources against the unique which may come again tomorrow.

A GERMAN has calculated that the average duration of life in the profession was in the sixteenth century 36.5 years, while now it is 56.7 years. The increase is due to preventive medicine.

A GROUP OF CASES IN ABDOMINAL SURGERY.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, SEPTEMBER 12, 1894.

By M. Price, M. D.,
Philadelphia, Pa.

CASE I.—Miss McC., a patient of Dr. Henry Lehman, suffering from a large multilocular tumor of the right side, which had been noticed for several years but gave no trouble. All at once it developed very rapidly, with symptoms of peritonitis and every indication of twisted pedicle. She was sent into the hospital, and the operation done at once. The tumor was a large, intensely black-looking mass adhering to the entire abdominal viscera, but the adhesions were easily broken, the tumor emptied and removed. The pedicle was found to be twisted four times. Rapid and uninterrupted recovery.

CASE II.—Mrs. M. J., a patient of Dr. George L. Romine, Lambertville, Pa., suffering from nodular fibroid of the uterus of five years' standing. Suffering from marked nervous excitement and depression alternately. Mental symptoms very marked. Operation—removal of both sides. Rapid recovery, with disappearance of all physical and nervous symptoms.

CASE III. — Miss L. P., Bouvier Street, a patient of Dr. Murphy. This patient had been suffering for a long time with pelvic disease; had been treated by a number of practitioners. None seemed to discover her trouble until Dr. Murphy carefully examined her case and suspected extra-uterine pregnancy. She asked me to see the case and confirm her diagnosis. I did so, and she was sent into the hospital for operation. The right side was an old and capsulated extra-uterine pregnancy and clot. The removal of the specimen, sac, and blood; irrigation, glass drainage, and rapid recovery.

CASE IV.—Miss D., eighteen years of age, a patient of Dr. Rush Leaman. This patient has been suffering from chronic gonorrhea for a year. She was beautiful, but uncontrollable morally; had one miscarriage. Dr. Leaman asked me to see the case after the girl had been suffering a number of weeks with peritonitis. The doctor had been called a few days previous, and stated to me that she was suffering from gonorrheal pelvic disease. My examination confirmed his opinion; also his recommendation that an operation was the only thing that would relieve her. She was taken to the hospital and both sides removed. When the tube was brought outside the abdomen ugly irritated gonorrheal pus poured from the fimbriated extremity of both tubes. The peritoneum was thoroughly irrigated; glass drainage twenty-four hours. When she left the hospital, four weeks afterward, she was in perfect health. After the operation she stated that at no time since had she suffered as she did weeks before the operation.

CASE V.—Mrs. S. S., Twenty-first and Diamond Streets, suffering from trouble in the right side in the region of the appendix; unable to walk without supporting that side. When walking stooped toward the right side. Had been ailing five years, and for three months before the operation was a confirmed invalid. Appendicitis was suspected. There was great tenderness over the appendix, but no induration or tumor that could be discovered. She was opened in the median line, and the right tube and the vermiform appendix were found glued together with an abscess of the tube and also one of the appendix. The vermiform appendix was carefully tied off, the diseased uterine appendage also removed, and the patient made a rapid recovery, with the entire removal of all symptoms.

CASE VI.—Mrs. R., thirty-four years of age, a patient of Dr. Clara Dercum. This is an exceedingly interesting case because there seemed to be some doubt

as to the diagnosis of her trouble. Several good practitioners carefully examined her, and wavered between multilocular cyst and pregnancy. Twice they went to the house to operate, but decided to wait, owing to the inability to say just what the trouble was. She fell into the hands of Dr. Dercum, and she at once decided it was a multilocular cyst. I was asked to see the patient to operate. I did so with the assistance of Dr. Dercum, Dr. Joseph Price, and Dr. George Hughes. I found the tumor to be a multilocular cyst of the right side, weighing about thirty-five pounds. She made an uninterrupted recovery. Operation in the hospital.

Case VII. — Mrs. L., twenty-six years of age ; two children ; suffering from double ovarian and tubal disease. This woman has been delivered by me twice of fine boys. After her first confinement she was badly diseased by her husband after his regiment returned from camp. It was very hard to get her to continue the treatment sufficiently long for her to get perfectly well. The vaginal discharge continued until the second boy's birth. There were no symptoms of ovarian or tubal disease at that time, but I thought it doubtful that she would ever become pregnant after her first delivery. She conceived and went to term notwithstanding. I took all precautions during its delivery, and of the child's eyes immediately after the delivery. The baby had an angry purulent ophthalmia. The mother seemed to make a satisfactory recovery, but was again infected by her husband five weeks after the delivery, and continued to do badly, having repeated attacks of pelvic inflammation, which would get better but not well. After a year and a half of chronic invalidism she had well-marked disease on both sides. I had her taken to the hospital, and both sides removed for pus tubes and ovarian abscess ; on one side glass drainage. She make a most satisfactory recovery.

Case VIII.—Mrs. F. S., Trenton, N. J., a patient of Dr. Joseph Shaw; a colored woman, aged eighteen years, married, no children. Apparently in perfect health up to three months prior to the operation. She then began to rapidly enlarge and suffer from pressure symptoms. I carefully examined the patient with Dr. Shaw, and we decided that it was a fibroid undergoing malignant changes. She was at once sent to the hospital, and the entire tumor and womb extirpated. She made a rapid and uninterrupted recovery.

Case IX.—Mrs. C., Trenton, N. J., a patient of Dr. Joseph Shaw; large ovarian tumor, which had been mistaken for pregnancy by two good men, when Dr. Shaw was called in to treat the case. He decided it was ovarian disease, and asked me to see her in consultation. We had no trouble in coming to a conclusion that it was a multilocular tumor. The patient had previously been prepared for operation by Dr. Shaw, and with his assistance and that of Dr. George Hughes, I at once removed the tumor. She made a rapid and uninterrupted recovery.

Case X.—William H. H. S., eleven years old, a patient of Dr. Hollingshead, Pemberton, N. J., was taken July 25 with pain in the right iliac fossa. He was freely purged, but without any benefit. On the first day of August there was free discharge of pus from the bowel; this relieved him temporarily. On August 3 he was seized with very severe pain on the right side. This continued to increase in severity, and I was telegraphed for. I found the boy suffering with severe pain on the right side, with an indurated mass extending from a little below the crest of the ilium to the region of the right kidney. An incision an inch and a half long was made over the most prominent point of the induration; a quantity of pus was discharged, and also discharged from the bowel. The head of the colon was full of small openings. Thorough breaking up of adhesions in the pus cavity, which seemed to be sacculated; thorough irrigation, and gauze and rubber drainage. This was removed on the second day, and light gauze packing used for several days longer, and the wound allowed to granulate from the bottom.

This is the fourth case of appendicitis operated on for Dr. Hollingshead within

the last two years, two of the four having fecal fistula, which healed in from five to six days. All the cases were within the radius of a mile, and all recovered.

Case XI.—Mrs. Rebecca V. S., thirty-two years of age, a patient of Dr. Hollingshead, Pemberton, N. J. Mrs. S. has been an invalid for two or three months, suffering from pain on the right side. She was completely incapacitated for work for about three weeks. She is the mother of the boy just reported, who was operated on for appendicitis. They were both in the same bed, the boy too ill to be removed, and he was operated on at once. The mother was removed to Dr. Joseph Price's private hospital, and was there operated on by me. She was suffering from a right tubal abscess, which had ruptured, producing local peritonitis, an affection of the pelvis, with abscess. Both sides had to be removed, a sac of abscess enucleated. Free irrigation, glass drainage. A great number of bowel adhesions in this case had to be broken, some stitching of the bowel necessary. The patient made an uninterrupted recovery.

Case XII.—Dr. F. H., of Columbia, Pa., was operated on on August 9 for an abscess on the right side, underneath the ribs. Its capsule was made up anterior on the abdominal wall and peritoneum; posterior between the liver and the peritoneum. An inflammatory diaphragm only. The abscess contained only probably half a pint of pus, and pushed against the diaphragm, giving him severe hiccough and spasmodic cough. It originated two years ago, from a fall on his doorstep in Columbia. His ribs were supposed to have been broken, and he was seen by Dr. J. W. White, of this city, and strapped, which gave great relief at the time. He was afterward seen by Dr. W. W. Keen, who advised him as to his case. I saw him about six weeks before the operation and advised him to have the trouble removed. He said he would as soon as he could, and on the 9th of August, in this city, I operated, irrigated, and drained the pus cavity. He made a rapid recovery. The feature in this case to which I wish to call your attention is the fact that it was two years in developing. The pus was perfectly sweet and bland. At the time of the operation he was greatly broken down from pain and cough.

Case XIII.—Mrs. R., patient of Dr. Eckman, twenty-eight years of age; three children; confined to bed for three months with symptoms of tuberculosis —only a very slight cough. After a very careful examination of the sputa, no tubercle bacilli could be detected; a careful pelvic examination showed well-marked pelvic inflammatory disease, womb fixed, and exceedingly tender masses on either side. Her temperature was never normal; she had daily chills; abdomen tender, with a history of puerperal peritonitis thirteen months previous.

The absence of positive proof of general tuberculosis and the presence of sufficient pelvic trouble to account for her symptoms warranted us in operating for her relief. There were no symptoms of dropsy.

The patient was operated on, and general tuberculosis of the peritoneum, with all the viscera matted together and covered with tubercles, was found to be the cause.

All the adhesions were separated and the bowels, omentum, and mesentery dusted with iodoform. The operation did not make any change in her so far as we could see, either for better or worse; she lingered until the eighth day, and then died. Post-mortem was made by Dr. Eckman, and general tuberculosis was found to be the cause of death.

There is one question that suggests itself in this case: Why was there no dropsy? Did its absence indicate general infection? I have seen many cases as bad as this accompanied with dropsy that the opening and iodoform treatment seemed to cure. In my knowledge, none of them show any symptoms today of tuberculosis.

There have been distributed about Boston one hundred and twenty-five barrels in which all scraps are placed, which otherwise would be thrown into the streets.

THE ADMINISTRATION OF STRYCHNIA DURING GESTATION.

Read before the Philadelphia County Medical Society, September 12, 1894.

By T. Ridgway Barker, M. D.,
Philadelphia, Pa.

In presenting this subject for consideration and discussion this evening it is not my purpose to depreciate or undervalue the great benefit the sulphate of strychnia is capable of rendering in a majority of the cases of pregnancy.

The claims made for it by my friend, Dr. Duff of Pittsburg, who has devoted himself with much enthusiasm to the study of this drug in its relation to obstetric practice, are not, I think, without justification; but, with the estimable conservatism of a seeker after scientific truth, he leaves the subject open for further study and research, awaiting until time and a wider experience shall prove its merits.

In a paper read before the South Side Medical Society of Pittsburg, and in one presented to the American Association of Obstetricians and Gynecologists, in 1893, he gives his clinical experience.

At the forty-fifth annual meeting of the American Medical Association, recently held at San Francisco, he again calls the attention of the profession to the value of strychnia, and points out that it renders abortions and premature deliveries less frequent by giving tone to the uterine muscles and nerves, as well as by its general tonic influence.

These statements are beyond question correct in the vast majority of instances; but he who would avoid error and misfortune must bear in mind that every rule has its exception, and that the latter, though often overlooked, is no whit less important than the former.

The sulphate of strychnia I have given to a score or more of women during gestation with the happiest results, and so general was the improvement in their condition that I began to think that there was no exception to this rule, but I was not long left in doubt, for, as the following case reported will show, I met the exception in a most unexpected but none the less pronounced form.

Mrs. G., primipara, aged twenty-nine years; white; general health good. Last menstruated in October; previously regular. Suffered greatly from morning sickness and distressing nausea for nearly four months, which was uninfluenced by internal medication. There was besides these symptoms, costiveness and a more or less irritable bladder. The appetite was poor, and loss of flesh was quite marked as the pregnancy advanced.

In the early part of the sixth month she first complained of a sense of weight felt in the abdomen and pelvis; this was soon aggravated by soreness and pain which persisted throughout the day and night. The nervous depression in this case was all out of proportion to the severity of the symptoms, and seemed to trouble the patient more than almost anything else.

There was no kidney trouble of any kind nor evidence of swelling of limbs or face. The heart was normal save a slight anemic murmur.

The blood was deficient in red-blood cells and showed a condition typical of that found associated with pregnancy. The woman, when married, weighed some one hundred and thirty pounds, but now was much emaciated. The vagina and cervix were normal and the uterus in good position; there were no adhesions.

To judge from the size of the abdomen and the activity of the fetus, development was progressing favorably. There existed, however, double ovarian tenderness, which denoted congestion of a pronounced type, and to this I ascribed in part the great mental depressisn, though, of course, much depended upon

the anemic blood supplied to the nerve centers.

Deeming this case one suitable for the administration of sulphate of strychnia from a careful analysis of the above objective and subjective symptoms, I determined to place the woman upon one-twentieth of a grain, twice a day, with the hope that it would stimulate a healthy nerve action and relieve, as has been claimed, the uterine irritability which threatened to result in an abortion.

I reasoned that the nervous disturbance was due to anemia of the central nervous ganglia and involved the sympathetic system as well.

That the uterus threatened to expel its contents because the nerves controlling its muscular coats were in a state of hyperesthesia dependent upon insufficient nutrition. With this idea I placed my patient upon the drug, which experience had proved to be the best suited to overcome just such a condition as I found present.

With what result? Within thirty-six hours the uterus became more rebellious; its muscular contractions increased rather than lessened in violence, and recurred with greater frequency. The dull pain which had persisted for several days now became acute and intermittent, and radiated from the umbilicus to the loins.

An abortion was undoubtedly threatened, and might almost be considered inevitable. The sulphate of strychnia was promptly discontinued, as it had undoubtedly only made matters worse, causing a passive uterine contraction to become active, and thus augmenting the expulsive uterine forces.

A sedative mixture containing morphia, chloral, and bromide of soda in solution, was ordered to be taken every hour, and the patient put to bed and directed to keep perfectly quiet. In a few hours the pains were allayed and the uterine contractions became feebler and recurred at longer intervals. These signs gave rise to a hope that the patient might yet escape an abortion.

Twenty-four hours elapsed with no return of the contractions. The prospect seemed to brighten, but only to give place within another twelve hours to a sudden and aggravated attack of pain, followed by strong uterine contractions, which, acting upon the cervix, soon overcame its constricting fibers, and an abortion was the result. In a few hours the whole uterine contents were expelled, much to the regret and disappointment of both physician and patient.

Thus ended one case of gestation in which strychnia may be said to have been the exciting cause of the abortion. Here we have what Duff probably refers to when he remarks in his paper, "I am not unmindful of the fact that I have seen apparent evil results from its administration in a few cases."

In looking over the history of the case reported, one cannot fail to be impressed with the fact that here was an instance where had one known the exception to the rule, he would not have given strychnia, since clearly it was contra-indicated.

Instead of its acting as a sedative to the hyperesthetic nerves through its tonic influence, it played the rôle of an excitant, and thus brought about the very result most to be deplored, namely, an abortion.

Some may take exception to the size of the dose (one-twentieth of a grain) twice a day; this I grant is not a small dose, but at the same time it is one I have frequently given with the best results, and I have found that a much smaller dose fails to be beneficial.

I do not, therefore, think that the amount administered made any material difference. That strychnia requires to be given during gestation with much more care than has heretofore been exercised, I think is very evident. Moreover, when there exists great mental depression associated with symptoms of distress and pain, referable to the pelvic region, with involvement of the uterus, I think the administration of strychnia is contra-indicated, for under such conditions it is more than likely it will act as an irritant and not as a sedative, and so will tend to produce an abortion, the very danger one is struggling to avoid.

Strychnia, then, it would appear, is

indicated in cases of gestation which require a powerful nerve tonic, but contraindicated when such cases are complicated by pronounced pelvic disorders of a nervous type.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING HELD SEPTEMBER 12, 1894.

Dr. M. Price read a paper entitled A GROUP OF CASES IN ABDOMINAL SURGERY. (See page 500.)

Dr. J. M. Barton: Dr. Price reported one case where he removed the uterus because it produced obstruction of the bowels, the patient being in collapse at the time of the operation. Under these circumstances the usual surgical procedure would be to make a temporary artificial anus by a small abdominal incision, to bring out a single loop of the distended bowel, the distention showing it to be above the obstruction, and to open it at once. This is the method of Mr. Treves, and is one I have used with some success on several occasions. If the patient rallies, extirpation of the uterus or such other radical surgical procedure as may then be resorted to, with the patient in a condition to stand the operation.

There is one point I would like to call attention to in the appendicitis operation reported. I understood the doctor to say that he does not close any portion of the abdominal incision. If not closed it is very liable to be followed by a hernia. In my earlier operations I had several cases of hernia, but in my later cases I have been fortunate enough to avoid this by using the gauze not as a drain, but only to isolate the rubber drain, and by at once closing nearly all the wound.

If the pus is deep I make the opening through the abdominal walls not less than four inches in length, and after opening the abdominal cavity, and before opening the abscess or attempting to remove the appendix, I prevent infection of the general peritoneal cavity by surrounding the place where I propose opening the abscess, with gauze, packing it under the edges of the incision so as to keep the movable intestines away from the wound and the danger of infection from the pus. The abscess is then opened and two rubber drains introduced to the bottom of it, and the abdominal wound closed by the interrupted suture, allowing only the ends of the rubber drains to protrude; the gauze is left inside, with only a corner showing, by which to seize and remove it on the third or fourth day.

The two stitches next the rubber drains are tied in a bow-knot so that they may be readily retied, if they have to be loosened to remove the gauze. All the cases in which I have used this method have recovered without any hernia whatever.

Of course, if the abscess is in contact with the anterior abdominal wall and the general cavity shut off by adhesions, no gauze packing is necessary, and the short incision, such as Dr. Price mentioned, is quite ample.

Dr. Ernest Laplace: I share the opinion of Dr. Barton that in chronic cases of appendicitis, where pus is isolated from the general peritoneal cavity, the more we treat the condition as one of abscess the more successful will we be. A small incision is not as good surgery as laying the abscess freely open so as to see what we are doing, not tampering, however, with the posterior wall of the cavity. Then the walls should be cleaned and irrigated, and the cavity packed gently with iodoform gauze. This gauze should be removed and replaced the following day. The more thoroughly we are able to apply the theory of asepsis the better will the case behave.

I take it that we cannot be too cautious in treating cases of chronic appendicitis. We must look at it as nothing but an abscess, and never look for the appendix unless it is to be easily found. If it is not removed it will do no harm and be imbedded with the rest of the cicatricial tissue during the healing process.

Dr. Marie B. Werner: There is one part of the paper which interested me

very much, and that is the question of the mental state in pelvic disease. About two years ago I made some investigations, as far as I was permitted, at the Norristown Insane Hospital. I examined thirty cases, and found 50 per cent. suffering from pelvic disease of some sort. Some, no doubt, would have been benefited by local treatment, others by operation. There were two on which I operated. One was a case of double hydrosalpinx. The patient had been insane since 1888. The operation was done in July, 1892. The patient is now, so far as I know, perfectly sane. This patient was seen by Dr. Thomas G. Morton, after dismissal, who verified my present statement. She left the hospital about eight weeks after operation. In the second case there was a cystomatous degeneration of one ovary and tubercular disease of both tubes and ovaries. The patient had had several attacks of insanity, and had been in Kirkbride's three times. Each attack had been preceded by an attack of pelvic inflammation. In this case the ovaries and tubes were removed, and the patient made a rapid and thorough recovery. I saw her afterward in her own home, and she was well, not only physically, but mentally.

I am sorry that I cannot speak of more than two cases, but these two cases show that there is a wide field for work of this kind. I do not wish to be understood as pleading for the knife entirely; I plead for thorough investigation and good treatment in these cases. In my own practice I have met with several cases which led me to think that much could be done in that direction. One which I distinctly remember occurred in my early practice. The patient was a young woman who felt that she must leave her baby or else she would kill it. She suffered from a laceration of the cervix and a complete laceration of the perineum. I repaired the lacerations, and she got well, but how long the cure lasted I cannot say, because she drifted out of my sight. It certainly lasted a few years.

Dr. J. M. Baldy: I did not care about discussing the paper; but since such emphasis has been laid on the nervous phenomena in connection with fibroid tumor, I should not like the statements to go out from the Society apparently sanctioned by my silence. In a very large number of fibroid tumors (hundreds) I have not seen one in which there was any insane symptoms. Thinking over my cases, I should say that they are decidedly more free from nervous phenomena than any other class of gynecological cases; certainly more than the pelvic inflammatory cases. As to insanity being due to gynecological troubles, I have a number of times been called to insane hospitals to see patients whose friends were possessed with the idea that their insanity was due to pelvic disease, and in not a single instance have I found the slightest disease to which the insanity could be attributed. I do not believe that the subject has anywhere near the importance that has recently been attempted to be given to it.

Dr. W. Easterly Ashton: In a large experience with fibroid tumor I have certainly seen no symptoms that would in any way point to a disordered state of the mind. It is true that some of these women are nervous, but anyone would be nervous suffering from constant pressure. Outside of the nervousness caused by the physical inconvenience of the tumor women have no mental symptoms.

It seems to me that the statement of Dr. Price in reference to fibroid tumors causing insanity is in line with another idea that has been advanced in regard to these growths, namely, that all fibroid tumors should be removed by operation. I am far from convinced that every fibroid uterus should be removed. The idea of insanity associated with fibroid tumors seems to be an additional plea for this form of surgery. As long as a fibroid tumor of the uterus is small and uncomplicated by pelvic trouble I see no reason why the woman should be subjected to abdominal section. The tumor should be carefully watched, and if it grows or shows signs of inflammatory changes, then it must be removed.

Before I sit down I should like to ask Dr. Price for an explanation. Last spring at one of the meetings of the Ob-

stetrical Society I made some remarks on the exploratory incision, and made the statement that in a large percentage of obscure cases I would give very little for the positive diagnosis of any surgeon. Growing out of this statement Dr. Price stated that in no instance had he ever opened the abdomen unless he could put his finger on the disease. I would, therefore, ask what led him to operate on the case of suspected appendicitis, if the diagnosis was uncertain?

Dr. G. Betton Massey: I can add my testimony in regard to the absence of any special mental manifestations in association with fibroid tumors. Out of a large number of cases I can recall none that presented such manifestations or more than the usual eccentricities of chronic illness. I wish to say, in regard to pelvic operations for mental disease, that there certainly is danger of overdoing them, and I speak from a medical experience of three years in a hospital for the insane. I must, however, temper my remarks by saying that as yet the gynecological treatment of the insane is an untried field in most of these institutions, and we should welcome any evidence of an increased scientific spirit among them.

Dr. Werner mentions a case where repair of the cervix and perineum were done in a case of puerperal insanity, and the patient got well. My view of puerperal insanity is that it is not due to an irritation such as that, but is an infectious disease. The disease is frequently curable of itself in six weeks. Possibly the criticism might apply to other cases, also that they were not of the ordinary chronic type of insanity.

Dr. John C. Da Costa: I agree with what has been said by Dr. Baldy and Dr. Ashton in regard to insanity not accompanying fibroid tumor. I do not think that Dr. Price meant to say that all these cases of fibroid tumors were accompanied by insane symptoms. I rather think that he intended to say that they were sometimes accompanied with nervous symptoms of a profound character. Where you have a woman with a tumor in the abdomen which she knows has to be taken out she naturally will be nervous until she has made up her mind positively that it has to be removed. My experience has been that so far as mental derangement is concerned—not nervousness—cases of fibroid tumor have been free from it.

In regard to operation in these cases, I agree with Dr. Ashton as to the propriety of letting small fibroids alone. When they grow rapidly or threaten malignancy it is time enough to take them out. I have now under observation cases of fibroid where I consider that operation would be so dangerous as to threaten life, and I am sure that by proper management they will tide over the menopause and get well if let alone.

Dr. Werner: I wish to state that the case in which I repaired the perineum and cervix was one that did not occur in my own practice as an obstetric case. She fell into my hands a year after the child was born, so that it could not properly be called an *acute* puerperal case.

Dr. Price: Replying to Dr. Ashton, I would say that if he looks over the case of appendicitis he will find that I put my finger on what I was going to remove. I knew that there was a diseased ovary and a diseased appendix—cut for it, and removed it. I think that for eight years I have never done an exploratory operation. I have never opened the abdomen to make my diagnosis, yet Dr. Ashton is in a measure correct. In abdominal surgery exactness is impossible, but a man who is not able to say when he has a big ovarian tumor or a big fibroid is certainly deficient in diagnostic ability, and should not operate until he is sure he has something to remove.

In regard to fibroid tumors of the character that Dr. Massey mentions, I never see them.

The patients never come to me until they are distressed by the condition and are suffering. In the thirteen cases reported there was not one in which the tumor was not larger than my head. When a tumor is of the size of a cherry-stone to that of a lima bean, such as Dr. Massey tells us about, I think that the knife should not be used. I agree that

they are electric cases if you can find them, but no one but an electrician can detect them. I think that if the cases of extensive fibroid disease are carefully examined it will be found that a number, I do not say all or nearly all, of them have mental symptoms that are marked, and border closely on the line of insanity. I do not say that of the pelvic cases with suppurative disease, any number of them are today in our insane asylums, and the list of insane could be materially diminished if these cases were properly treated. I agree with Dr. Werner when she says that she does not advocate the knife in all of these cases of insanity ; but if you can put your finger on the thorn that has driven that woman with pain and suffering to the mad-house, remove it. They are there by the hundreds, and operators throughout the country are saving hundreds from going there. If any one of you had a mass of pus in your abdomen with adherent omentum and bowel racking your constitution, your chances of going to the insane asylum would be ten times greater than they are now. I do not say that this condition of itself produces insanity, but it greatly predisposes to it. We can prove it by a number of cases that have come into the house insane and have gone out sane.

With regard to appendicitis, I think that Dr. Barton and Dr. Laplace misunderstood me. I agree with those gentlemen except as regards the incision. I have had twenty-three cases and two deaths. One was a case of Dr. Collins, which could have been saved if they had listened to Dr. Collins. The second case died of sepsis present at the time of operation. In two cases the appendix was removed. These were median operations. When the appendix is to be removed, I believe that it should be a median operation. Where you remove the appendix the symptoms of abscess are not so marked, but you have symptoms of obstruction of the bowel. Here you have to make a median incision in order to detach the adhesions. If you find that the abscess is mapped off from the peritoneal cavity you can make a drainage incision above the crest of the ilium. In the cases that fall into my hands there is generally a well-marked abscess, and drainage is the only indication, and no effort is made to find the appendix.

I think that the practice of packing the whole abscess with gauze is unsafe. I think that if these cases are opened, irrigated, and a gauze and rubber drain put in, the gauze being replaced every twelve or twenty-four hours, they will all get well. I do not care if the whole head of the colon is gone, they will get well without a fecal fistula. I have seen large quantities of feces pour out for eight or ten days and the opening finally close. If you make the incision too long you may go beyond the abscess cavity and get into the abdomen. A two-finger opening will enable you to do all that is necessary.

CORRESPONDENCE.

AN INVITATION.

CUMBERLAND, MD.,
Oct. 1, 1894.

Editor MARYLAND MEDICAL JOURNAL.

Dear Sir:—I am directed by the President of the Tri-State Medical Association, Dr. S. S. Good, to extend through the columns of your Journal a cordial invitation to all members of the Maryland Medical and Chirurgical Faculty to attend the sessions of the Tri-State Association on November 20, 1894, in this city. As the Faculty convenes here on the day following it is thought members could attend both meetings with pleasure and profit. Professors Tiffany of Baltimore, Montgomery of Philadelphia and Lange of Pittsburg will be present and read papers.

Very respectfully,
E. T. DUKE, M. D., Secretary.

THE PNEUMATIC CABINET.—A good instrument should not be discarded because unskilful hands have brought it into ill repute. Dr. Quimby of New York and Dr. Vincent Bowditch of Boston both use the old pneumatic cabinet in properly selected cases with excellent results.

MEDICAL PROGRESS.

DIPHTHERIA AND CROUP FOLLOWING TONSILLOTOMY.—The fact that the apparently healthy mouth may contain dangerous organisms has been shown again and again. After recovery from diphtheria and pneumonia the organisms remain in the mouth for days and weeks. Dr. Augustus Caille reports a case in the *Archives of Pediatrics* of a boy with carious teeth and adenoid growths on whom he did tonsillotomy with the result that a diphtheritic membrane was deposited wherever the mucous membrane had been cut or wounded. He treated the case promptly, at the same time having the carious teeth extracted or filled, using constant antiseptic irrigations of the nose and mouth, which caused the organisms to disappear. His methods are as follows :

1. In the present state of our knowledge the possibility of preventing diphtheritic infection of the naso-pharynx cannot be denied.

2. The municipal control of diphtheria in large cities is inadequate and methods of personal prophylaxis are more apt to prevent infection.

3. A daily toilet of the naso-pharynx by means of weak antiseptic solutions is a trustworthy method of prevention in the absence of filthy carious teeth and enlarged or inflamed tonsils and adenoid vegetations.

4. The naso-pharyngeal toilet is indicated for all those who are exposed to diphtheritic infection and as a routine treatment in every case of naso-pharyngeal catarrh, pertussis, scarlatina, measles, and before removing tonsils and adenoid vegetations to prevent diphtheritic infection as a complication.

5. The following solutions may be employed :

Weak salt solution.

Boric acid solution, 2 per cent.

Labarraque's solution, 1 to 20.

Bichloride of mercury solution, 1-5000.

Weak (rose colored) permanganate of potassium solution.

Lime water.

6. In a case requiring tonsillotomy in which filthy carious teeth and adenoid vegetations exist at the same time, the carious teeth should first be extracted or filled, and the naso-pharynx should be irrigated for a week previous to operation, and it would seem advisable to ascertain by means of a swab culture the presence or absence of diphtheria bacilli before operating on the tonsils and on adenoid vegetations.

* *
*

URINE INDICATIONS IN ANESTHESIA.—The examination of the urine is a very important diagnostic aid and will often throw light on an obscure case. Dr. William H. Porter in the *New York Medical Abstract* believes that we may draw deductions as to the safety of anesthetics by examination of the urine. From his investigations he concludes :

1. That ether and chloroform act upon the same principles, but with results developed by slightly different methods.

2. That both are capable of producing death at the time of the anesthesia ; chloroform more frequently than ether.

3. That ether causes as many, if not more, deaths than chloroform, but the fatal issue is delayed until the patient has been removed from the operating table.

4. That by a careful study of the density of the urine and its causes, we are in possession of exact information by which we can determine the precise nutritive condition of the system, and be forewarned as to the possible outcome of the anesthesia. It also enables us to judge which anesthetic is best adapted to the individual case in question.

5. We are taught that neither ether nor chloroform should be administered until the glandular organs, in their necessarily damaged states, are put in the best possible condition to endure this extra strain. When this is a general rule many cases that now prove fatal will be saved.

6. It teaches that every public institution should have a paid physician who is competent to examine the urine, and determine through it the status of the physiological economy before giving the anesthetic. It should also be the duty of this same physician to adminis-

ter the anesthetic, for he alone knows best which anesthetic to select with a given condition of the system, and is also better able to guide the patient safely through the anesthesia than one who knows nothing of the constitution of the patient except from a second party.

7. While it is clear that death in some instances is directly due to the primary effects of the ether and chloroform, and in others to secondary effects, it should not deter us from using them, but stimulate us to be more thorough masters of their actions upon the system, and thus to guard against their ill effects. When all this is accomplished, chloroform will probably hold the first place as an anesthetic.

* * *

Operative Treatment of Paralytic Deformities.—Dr. De Forest Willard expresses the opinion in the *Archives of Pediatrics* that deformities from infantile spinal paralysis are improved by surgical or mechanical measures. His conclusions on this subject are :

1. Prevention of deformities by means of apparatus and other measures is exceedingly important.

2. When contractions have occurred, the employment of surgical measures should, as a rule, precede the application of mechanical appliances. To attempt to overcome these deformities by mechanical means is to needlessly inflict great pain and to consume much time, and the final result is no better than when surgical procedures are employed.

3. Myotomy and tenotomy, either subcutaneous or open, are perfectly safe operations ; they are usually remarkably effective and leave the muscles in a better condition for action than before the operation.

4. In contractures at the hip, free open incision is usually preferable ; at the knee, subcutaneous section can frequently be performed, but when fascial contractions occur in the central popliteal space, open incision is necessary, and excision is occasionally demanded. At the foot, subcutaneous division is usually sufficient ; tarsectomy is seldom necessary. Fasciotomy is frequently required.

5. Forcible straightening following division is important. Rectification should be complete at the time of operation, and all contracted tissues should be divided.

6. In spastic paralysis, lengthening the tendons by tenotomy assists in restoring muscular equilibrium and consequently secures better subsequent locomotion.

7. Free section of the abductors is often advisable.

8. The best subsequent dressing for maintaining abduction while the patient is in bed is the application of a rigid dressing to the knees. The legs can then be fastened widely apart.

9. Mechanical appliances with lock or stop joints are important, and artificial support by wheeled crutch or other measures will assist in restoring muscular power.

* * *

The Murphy Button.—The Murphy button has become such an important instrument in the hands of the abdominal surgeon, that few are at the present time skeptical of its utility. Dr. C. E. Ruth of Keokuk having used it in a number of different cases, expresses his opinion in *Mathews' Medical Quarterly* that the following facts have been proven:

1. That the Murphy button shortens the time required to do an intestinal anastomosis fifteen to forty minutes.

2. Properly applied, leakage is impossible, and no hydraulic or gaseous pressure is needed to determine the fact.

3. It is the strongest junction known.

4. It gives the minimum of cicatrix and of contraction.

5. It is the only plan that can be relied upon to make the ideal end-to-end junction.

6. After completing its work it leaves no foreign body of any kind behind.

7. The idea of the button causing obstruction by failing to pass the ileo-cecal valve is a myth, if any judgment be used with reference to the relative size of the button selected and the gut operated upon.

8. The greatly lessened mortality

makes this hitherto almost impractical field of work compare favorably with other intra-peritoneal operations.

9. It should relegate fecal fistulæ following operations for strangulated hernia and intestinal resections to the past.

10. No care need be taken to have the proximal and distal portions of the gut correspond in size.

* * *

Stomach Diseases of Women.—The majority of women, especially of the more ignorant class, make no distinction between "stomach" and "abdomen," and when they have pain in the genital regions, they say they have pain in the stomach. This is most usually from ignorance, but Dr. Byron Robinson in *Mathews' Medical Quarterly* attributes it also to reflected pain. He concludes as follows:

1. Reflex neurosis in the viscera is nearly always from the genitals.

2. The genitals are more liable to disease than any other viscera.

3. The genitals have the most intimate and profound nervous connection of all viscera.

4. In reflex neurosis bowel troubles are chiefly secondary to genital disease.

5. In my experience in gynecological clinical work, in nearly all cases who complain of stomachic disturbances it was found that the genitals had well-established disease.

6. It was also observed that as the genital disease recovered the stomach difficulties gradually decreased.

7. The gradual steps in reflex neurosis in a patient are: (*a*) some point of irritation (genitals), (*b*) indigestion, (*c*) malnutrition, (*d*) anemia, and (*e*) neurosis.

* * *

Physiological Rest in Prolapse of the Rectum.—Extreme prolapse of the rectum is a condition very difficult to treat, an operation often not giving satisfactory results. Dr. Joseph D. Bryant has operated in several cases, and his theory confirmed by practice is that if the rectum can be given physiological rest, great improvement, and perhaps even cure, will be the result. His conclusions recorded in *Mathews' Medical Monthly* are:

1. That the proper performance of the physiological functions of the rectum contribute greatly to the advancement of rectal disease and to the sufferings of the afflicted.

2. That the complete vicarious discharge of the feces through an artificial anus located in the sigmoid flexure reduces the physiological demands on each structure of the rectum to a minimum.

3. That the lessening of the physiological requirements is commonly in direct proportion to the diminution of the fecal flow through the rectum.

4. That the cessation or lessening of the fecal discharge *per rectum* exercises a palliative influence on diseases of the rectum.

5. That in certain cases of obstinate rectal prolapse the formation of a vicarious channel for fecal discharge is justifiable, both as a palliative and curative measure.

6. That the preliminary establishment of such a channel for the purpose of cleanliness and the prevention of infection is justifiable in many grave operations for prolapse of the rectum.

7. That the dangers attendant on the formation of an inguinal anus are much less than those invited by the contact of fecal discharges with large operative surfaces of the rectum.

8. That the case just presented has been, without special risk, greatly benefited, and may be finally cured through the agency of an artificial anus.

9. That when cure takes place great care must be exercised thereafter, otherwise the prolapse will return.

* * *

Traumatic Peritonitis in Children.—Dr. G. Frank Lydston says:

1. I do not believe in acute primary idiopathic peritonitis.

2. The majority of cases of so-called idiopathic peritonitis in children will be found upon inquiry to be traumatic.

3. Slight injuries of the abdominal wall are relatively more dangerous in children than in adults.

4. Surgical interference is indicated in all cases of severe general peritonitis and cases of localized suppurative peritonitis.

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BALTIMORE, OCTOBER 13, 1894.

THE death of Oliver Wendell Holmes, poet, author, physician, cannot but cast a gloom over all those who admired the man and his works. Dr. Holmes was a man of such versatile talent that more than one profession can claim him. In his earlier days he studied law, and later he took up medicine, to which he gave so much attention that he stood high in his class, and during the few years following that he practiced in and out of hospital he carried off three Boylston prizes, in one of which he first brought out the idea of the contagiousness of puerperal fever and gave the first hints of its bacterial origin.

Oliver Wendell Holmes.

As professor of anatomy at Harvard he paid strict attention to his duties, yet his natural bent led him to general literature, which has perhaps given him his great reputation. Although he practiced medicine for a few years only and long ago ceased to lecture at Harvard, he always had a fondness for the science of medicine. It is wonderful to think that a man who could make interesting such a dry, unsentimental study as anatomy was able to write poetry and prose of deep feeling, and yet he was not devoid of a keen sense of humor, as is shown in his sayings and in some of his unpublished poetry. His loss will be felt for a long time to come.

* * *

IN some diseases the patient has the sympathy of the family, friends and ofttimes even of the physician, while in other diseases that virtue is obtained from all except the physician. Hysteria is a diseased condition which usually elicits little sympathy from the practitioner of medicine, and Dr. Gustavus Eliot thinks we do not pay it sufficient attention, and attempts to show in the *New York Medical Journal* what the gravity of this condition is.

The Gravity of Hysteria.

Sir Thomas Watson considered it a distressing disease, but never fatal, and indeed it always left the patient with no lesion of mind or body. Whatever the physician may think of any disease, he should never underestimate it, and in this case it is a question, says Dr. Eliot, if hysteria has not been considered too lightly. Rough means may abort an attack and banish all sympathy for the patient, but such attacks leave an impression on the woman and this disturbance of the nervous system may lead on to neurasthenia, neuralgia or melancholy. The hysterical woman who marries may bring up children with epilepsy, or even insanity.

Dr. Eliot thinks it is a mistake to say that persons do not die of hysteria. They do. It is also well to pay more attention to the disease and show more sympathy and less brutality. It is true that physicians feel provoked at some hysterical patients, still it is rare for a man with tact to spare sympathy in such cases, for aside from everything else such cases, while being very troublesome and annoying, are a constant source of revenue, and proper care and sympathy, even if cure does not follow for a long time, bring great credit on the physician's head, and such tact and skill are appreciated. Dr. Reed says in conclusion that it should never be forgotten that:

1. Hysterical manifestations indicate an abnormal condition of the nervous system.

2. This condition will be aggravated if the patient is not properly treated.

3. Prolonged or frequently repeated attacks

may inflict serious and permanent damage upon the nervous system of the patient.

4. As a consequence, a tendency to functional disorders of the nervous system may be transmitted to the children and grandchildren of the patient.

5. Serious symptoms and even death may be caused by hysteria.

* * *

Physicians' Fees.

RECENT articles in prominent monthly magazines on the pay of physicians have brought out discussions and opinions on this subject from many different quarters. The general opinion expressed seems to show that physicians in many cases were not only underpaid, but they have great difficulty in collecting their money. That such conditions are not of recent occurrence is shown by the letter written almost four hundred years ago by an English physician:

JON'E FRYAR'S FEES.

A singular letter has been preserved in the Record Office among the uncalendared papers of the latter end of Henry VIII's reign, illustrating the views physicians of the time held regarding their patients and their fees, and is worth recording not only on that account, but in relation to the life of the bishop. The paper is 30 Hen. VIII U 198 :—

MY SINGULAR GOOD LORDE.—After my most bounden duetye to your Lordshypp, this shalbe to advertyze the same, that wheras of late the Byshoppe of Rochestre at what tyme he was sycke, requyred me to loke to hyme and to gyve attendawnce on hyme bothe nyght and daye, promysynge to recompense my labour and payne, and wher after he was departede, all hys goodys war taken upp by Mr. Gostwycke and converted to the Kyngs Coferys, so that for xii dayes labour, and iiij nights watchyng, as yet I have recoveryd nothynge, in so motch, that except your lordshype be good to me, I shall bothe lose my labour, my frende and also my physycke, and truely if physycyens shuld take no monye for them that they kyll, as well as for them that they save theyr beying shulde be very thyne and bare, therfor I beseche your good Lordshyppe as to send to Mr. Gostwyeke that I may have some recompense and rewarde for my payns. And I beseche your lordshyppe it may be so motch the more liberall, becawse it shalbe the last payment, for of them that scape we may take the lesse, because we hope they shale ons come agayne into our handys. I beseche your good lordeshypp, as I have in many other thynge ever fownde yor Lordshype good to me, so also in this my poor requet, lett me not be destitute of your wonte favor and goodnes towarde me, as I shal daly pray for the preservation of your healthe, the whyche I pray God longe to maintayne and kepe in all honor and felicytie.

from London the xvith of August

Yor Lordshypp hys most humble servaunt JON'E FRYR physytyen.

To my ryght honorable and my singular good Lord, my Lorde Privy Seale.

* * *

The Dangers of Cocaine.

ALMOST every drug, indeed every therapeutic agent, has its power to do good and to do harm. Alcohol, opium, chloral, are all indispensable and all have proved a blessing and a curse to mankind. The newest dangerous remedy is cocaine and Dr. D. Bryson Delavan has pointed out in the *Journal of the American Medical Association* the necessity of clearly marking out the indications for the use of this powerful remedy and emphasizes the care necessary in prescribing it. Medical men who have been the readiest to order it freely and disclaim its harmfulness are the very ones who have become its victims. The manufacturers of proprietary medicines have discovered its power and by false statements have lured many on to their destruction. Physicians have carelessly prescribed it and have started the habit in a weak, nervous member of humanity. When it is given great care should be taken and discrimination used. The following suggestions are offered :

1. Cocaine, one of the most useful of drugs, is capable of being more harmful than even alcohol or opium.

2. The use of cocaine is increasing to a serious extent.

3. For this the medical profession is largely responsible.

4. It is the duty of the profession to guard the public by every proper means against the dangers arising from the use of cocaine.

5. To this end, it is desirable that the careless use of cocaine should be discountenanced: *a*, by manufacturers of proprietary medicines; *b*, by the general public ; *c*, by the general profession ; *d*, and, lastly and particularly, by the department of rhinology.

MEDICAL ITEMS.

Dr. Oertel, the assistant superintendent of the Hygienic Institute of Hamburg, met his death recently by swallowing infected water as an experiment.

Rumor says that the position of Professor of Surgery in Tulane University, New Orleans, was offered to and refused by Dr. L. McLane Tiffany of Baltimore.

Dr. A. H. Buckmaster of New York, editor of the *Journal of Gynecology and Obstetrics*, has accepted the call to the chair in the University of Virginia made vacant by the death of Dr. W. C. Dabney.

The new Maryland General Lying-In Hospital is now complete and ready for occupancy. Besides the public wards where every convenience is at hand, there are private rooms to which private patients may be sent. Drs. Wilmer Brinton and J. Frank Crouch are the attending obstetricians.

At the meeting of the University of Maryland Medical Society held last Tuesday night, the following officers were elected for the ensuing year: President, Dr. Charles W. Mitchell; Vice-President, Dr. Randolph Winslow; Secretary, Dr. John Turner, Jr.; Executive Committee, Drs. J. Holmes Smith, St. Clair Spruill and C. O. Miller.

At the 297th Regular Meeting of the Clinical Society of Maryland, the following officers were elected for the ensuing year. Dr. J. H. Branham, President; Dr. J. M. Hundley, Vice-President; Dr. H. O. Reik, Recording Secretary; Dr. William K. Robinson, Corresponding Secretary; Dr. W. J. Todd, Treasurer; Dr. Aaron Friedenwald, new member of Finance Committee; Drs. C. Hampson Jones, Henry B. Thomas and T. C. Gilchrist, Executive Committee.

The College of Physicians and Surgeons announces the following clinics at Bay View, to which the profession are invited: Medical, Dr. Preston; Diseases of the Spinal Cord, Thursdays, October 11, 18, 25 and December 1. Dr. Latimer; General Medicine, November 8, 15. Dr. Julius Friedenwald; Diseases of the Stomach, November 22, 29, December 6 and 13. Surgical Clinics, Dr. Chambers; Tuesdays, October 9, 16, 23, 30. Dr. Branham; November 6, 13, 20. Dr. W. F. Smith; Genito-Urinary Diseases, November 27, December 4, 11, 18.

WASHINGTON NOTES.

Dr. J. B. Harding of Washington, D. C., and a native of Virgina, died in Washington, in his seventy-fifth year.

The Medical Association of the District of Columbia, Dr. George Byrd Harrison, the President, in the chair, held its semi-annual meeting on the night of October 2. A large number of members was present. There were sixteen applicants for membership. Twelve were elected, two were rejected and two withdrew their applications.

Typhoid fever is somewhat on the decrease in Washington, but this is only presumed by the number of death certificates sent in, certifying the cause of death. The Health Officer is desirous of having it compulsory to report cases of typhoid fever, just as for diphtheria and scarlet fever cases. Then these cases could be investigated by the sanitary inspector; but unfortunately there is no law compelling it.

The 213th meeting of the Washington Obstetrical and Gynecological Society was held Friday night. The annual address was delivered by Dr. H. D. Fry, President of the Society, who gave a history of Puerperal Infection, and its gradual decrease from the time antiseptics were brought into use was cleverly shown by charts. After the reading of the paper, the Society was invited by the President to a collation.

The Columbian and Georgetown Universities opened on October 1. Dr. E. A. De Schweinitz, Professor of Chemistry, delivered an able opening address for the Columbian University. The Georgetown College had no opening addresses, but commenced work immediately. Great improvements have been made in the Chemical Laboratory, under the charge of Professor J. J. Stafford, in procuring new apparatus.

The Medical Society held its first meeting October 3, Dr. S. C. Busey, the President, in the chair. Twenty-three new members were elected, none rejected. Dr. Busey urged the members of the Society to work on their respective representatives in Congress to aid in passing laws regulating the practice of medicine in the District; also the sale of milk. A motion was also made to endeavor to get a law passed entitled "The Prevention of Desecration of Graves and the Promotion of the Study of Anatomy."

BOOK REVIEWS.

A MANUAL OF HUMAN PHYSIOLOGY; Prepared with special reference to students of medicine. By Joseph H. Raymond, A. M., M. D., Professor of Physiology and Hygiene in the Long Island College Hospital, and Director of Physiology in the Hoagland Laboratory. With 102 illustrations in the text and 4 full-page colored plates. Philadelphia: W. B. Saunders. 1894. Pp. 382. Price $1.50.

It is very hard to say anything new on a work on physiology. The author, with an experience of twenty years as a teacher of this branch, has produced a very practical little book. It is evidently written for students. The effect of alcohol on the tissues and organs is very properly made an especial point. The illustrations are particularly good. This is one of Saunders' New Aid Series.

ESSENTIALS OF THE DISEASES OF THE EAR; Arranged in the Form of Questions and Answers. Prepared especially for Students of Medicine and Post-Graduate Students. By E. B. Gleason, S. B., M. D., Clinical Professor of Otology, Medico-Chirurgical College, Philadelphia, etc. Philadelphia: W. B. Saunders, 1894. Pp. 147. Price $1.00.

This is number 24 of Saunders' Question-Compends and is prepared especially for post-graduate students. Like all such books, it is intended to supplement the lectures and demonstrations and to be used as a manual of reference in the dispensary.

REPRINTS, ETC., RECEIVED.

L'Ichthyol dans le traitement des uréthrites et des cystites. Par le Docteur Roberto Villetti. Institut de Pharmacologie expérimental de la R. Université de Rome.

Ueber die Beziehungen des Ekzems zu den Schleimhäuten. Von Dr. von Sehlen-Hannover. Sonder-Abdruck aus *Monatshefte für praktische Dermatologie.*

A Case of Cysticercus of the Vitreous. By W. Cheatham, A. B., M. D., of Louisville, Kentucky. Reprint from the *Annals of Ophthalmology and Otology*, 1894.

The F. A. Davis Company of Philadelphia announce an early issue of Practical Urinalysis and Urinary Diagnosis, by Charles W. Purdy, M. D., of Chicago. Part One will treat of the analysis of the urine, Part Two of urinary diagnosis and an appendix will be devoted to the examination of urine and life insurance.

CURRENT EDITORIAL COMMENT.

SPECIALISM.

American Medico-Surgical Bulletin.

THIS is the epoch of specialism. Appreciating the increased effectiveness of skilled labor through specialism in the manufacture of complex articles, recognizing the benefits of the entire devotion of the life of certain physicians to certain sub-divisions of the famous seven branches of medicine, the laity has arrived at a stage when "the specialist" has himself become a daily and universal necessity, and the term specialism "as familiar as household words."

ROUTINE.

Kansas Medical Journal.

IT strikes us that physicians, like other people, are subject to all the evil effects of routine practice. The expressions we often hear in medical meetings give the strongest evidence of routine practice. The physician who never uses ergot, never gives veratrum viride, is as much of a routinist as the one who uses ergot in every case of labor and gives veratrum viride in every case of puerperal convulsions. It is only a difference in the method. The man who adopts a routine method of treating his cases does not exercise that perception or discernment which evidences a complete understanding of pathological conditions.

SKILLED ANESTHETIZERS.

Medical Record.

WE believe that the time will come when every large hospital will have a regular salaried anesthetizer, who will always be available, and who will enjoy the same confidence in his department as the pathologist does in his own. Operations will certainly proceed more smoothly and safely; we shall hear of fewer deaths from "heart failure;" and cases of "ether pneumonia," and of "acute uremia from ether," will be almost unknown. The advantages to the operator will be immense. Instead of having his mind distracted by the struggles of a half-anesthetized patient, or being obliged to stop his work until she is revived from a condition of asphyxia, he will be able to give his entire attention to the operation, relying on the anesthetizer to note the danger signals, to administer stimulants when they are needed, and to keep him informed as to when he must hasten, or when he can proceed deliberately.

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NOTES.

PILOCARPINE is very effective in croup.

*

EUROPHEN is used very successfully in treating ulcers of a chronic nature.

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PSORIASIS and other skin diseases are successfully treated with thyroid extracts.

*

OXIDE of zinc is recommended in two to five grain doses, for nervous headache.

*

BISMUTH in enemata is often more effective in dysentery than when given by the mouth.

*

THE oil of eucalyptus is very efficacious in headache, especially when it is rheumatic or malarial in character.

*

APPLICATIONS of a five per cent. solution of cocaine in glycerine and water made to the breast will arrest the flow of milk.

*

PHOSPHORUS in the form of phosphorized cerebro-spinant is a powerful reconstructive and is excellent in some forms of impotence.

*

AMYL nitrite, which has been so highly recommended in puerperal eclampsia, may relax the muscles of the uterus to such an extent as to cause post-partum hemorrhage.

READING NOTICES.

Elixir Six Aperiens.—One of the great annoyances that attend pregnancy is *constipation.* We find the safest and best laxative a woman can take when in such condition is an occasional dose of *Elixir Six Aperiens.* The physician should see that his patient's bowels are thoroughly emptied a few days before confinement, for it is our experience that the woman who keeps her bowels moderately open especially before delivery has a much easier time.

*

Maltine with Coca.—"The American Disease," an irritable heart combined with indigestion and nervousness, so common among our business men and almost universal among women of the upper classes, presents a problem of ever-varying embarrassment to the clinician, says Dr. Stowell, editor of the *National Medical Review.* Alcoholics may mitigate the symptoms of this condition temporarily, but lead to disastrous results. To try to give relief with opiates is little less than homicidal. Maltine with Coca Wine is an ideal combination in these cases, not only on account of the coca, but from the food and diastasic values of the maltine, and is not followed by habit symptoms, for when the condition is relieved the remedy is no longer needed and its withdrawal is not followed by depression. In this particular coca differs from all other stimulants and narcotics.

DETECTIVES NEEDED HERE.

Superintendent Chas. Ainge, of the National Detective Bureau, Indianapolis, Ind., announces hat two or three capable and trustworthy men are needed in this county to act as private detectives under his instructions. Experience in the work is not necessary to success. He edits a large criminal paper and will send it with full particulars, which will explain how you may enter the profession by addressing him at Indianapolis, Ind.

*

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We are informed that the Modern Press Association wants one or two newspaper correspondents in this country. The work is light and can be performed by either lady or gentleman. Previous experience is not necessary, and some of our young men and women and even old men would do well to secure such a position, as we understand it takes only about one-fourth of your time. For further particulars address Modern Press Association, Chicago, Ill.

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